SMILEOLOGY™
IMPLANT, COSMETIC & FAMILY DENTISTRY

Child Patient Form

SMILEOLOGY.com

About Your Child

Child's Name: ________________ Gender: ________ Birthdate: ____________

Responsible Party Name: ________________ Relationship: ____________

Email Address: ________________ Marital Status: ____________

Home Address: ________________ City/State: ____________ Zip: ________

Home #: ____________ Cell #: ____________

How did you hear about us?

- ○ Website ○ Billboard ○ Newspaper ○ Seminar/Event ○ Magazine ○ Social Media
- ○ Friend/Family Member: ________________ ○ Other: ____________

Insurance

Insurance Company: ________________ Group#: ____________

Insurance Company Address: ________________

Policy Holder's Name: ________________ Relation: ____________

Policy Holder's SS#: ____________ Policy Holder's DOB: ________ Employer: ____________

Medical History

How often does your child brush? ______________________ Floss? _________________________

Is your child's water fluoridated? _________ Has your child ever taken FenPhen/Redux? _______

Previous Dentist: ___________________________ Date of last visit: __________________________

Has your child had difficulty with other dental visits? ____

Does your child? (Check all that apply)

- ☐ Take fluoride supplements
- ☐ Suck thumb/finger
- ☐ Speech problem
- ☐ Chew hard objects (pencils, etc.)
- ☐ Grind teeth
- ☐ Clench jaws
- ☐ Suck/bite lip
- ☐ Gag easily
- ☐ Tonsils/adenoids removed
- ☐ Bite/chew nails

What medications/supplements is your child currently taking? _______________________________

Does your child have any allergies? If yes, please list: _______________________________________

Any previous hospitalizations/surgeries/serious illnesses? _____________________________________

Has your child ever had any of the following? (Check all that apply)

- ☐ Abnormal bleeding
- ☐ Acid reflux
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital heart defect
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Handicaps/disabilities
- ☐ Hearing impairment
- ☐ Heart murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Osteoporosis
- ☐ Persistent cough/throat clearing
- ☐ Rheumatic fever
- ☐ Sensory problems
- ☐ Stomach, liver, or kidney problems
- ☐ Tuberculosis

Please list any other medical problems your child has: ___________________________________

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I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary services that may be needed during diagnosis and treatment with my informed written consent.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Signature of Parent/Guardian: __________________________ Date: _______________

I understand Smileology is not contracted with any insurance plan and I am responsible for payment of all services rendered for my child. I further understand that Smileology will file my dental insurance claim once I have provided them with my current, correct dental insurance information. I hereby authorize release of any information including the diagnosis and records of treatment or examinations rendered to my insurance company.

Signature of Parent/Guardian: __________________________ Date: _______________