

WELCOME TO CHARLESTON SMILES!

We are pleased you have chosen us as your / your child's dental provider!

We strive to make every visit as pleasant and comfortable as possible.

Please take a moment to let us get to know you / your child better!

PATIENT INFORMATION

NAME: _____ NICKNAME: _____
D/O/B: _____ SEX: M F AGE: _____ SSN: _____
SCHOOL: _____ GRADE: _____
HOME ADDRESS: _____ CITY: _____ ZIP: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ RELATION TO PATIENT: _____
HOME PHONE: _____ CELL PHONE: _____
OTHER PHONE: _____ E-MAIL: _____

- FATHER'S NAME: _____ D/O/B: _____
EMPLOYER: _____ SSN: _____
- MOTHER'S NAME: _____ D/O/B: _____
EMPLOYER: _____ SSN: _____
- RELATIVE OR FRIEND NOT LIVING WITH YOU:
NAME: _____ PHONE: _____

INSURANCE

- IS THE PATIENT COVERED BY MEDICAID? Y N
- DOES THE PATIENT HAVE ANOTHER DENTAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF PRIMARY INSURANCE CARRIER? _____ POLICY #: _____
INSURED'S NAME: _____ SSN: _____
EMPLOYER: _____ D/O/B: _____

SECONDARY INSURANCE CARRIER? _____ POLICY#: _____
INSURED'S NAME: _____ SSN: _____
EMPLOYER: _____ D/O/B: _____

CHILD'S DENTAL HISTORY

- HOW OFTEN DOES YOUR CHILD BRUSH? _____ FLOSS? _____
- PREVIOUS DENTIST? _____ DATE OF LAST VISIT? _____
- ANY DENTAL CONCERNS? _____

- DOES / HAS YOUR CHILD EVER:
 - SUCKED THUMB / FINGERS / LIP? Y N
 - HAD ANY INJURIES TO THE FACE OR MOUTH? Y N IF YES, PLEASE EXPLAIN: _____
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CHILD'S MEDICAL HISTORY

- PLEASE NOTE IF YOUR CHILD HAS OR HAS HAD ANY OF THE FOLLOWING:

AIDS / HIV	Y N	ASTHMA	Y N	AUTISM	Y N
BLOOD DISORDER	Y N	CANCER	Y N	DIABETES	Y N
DRUG / ALCOHOL ABUSE	Y N	EPILEPSY	Y N	FAINTING SPELLS	Y N
HEART DISEASE/MURMUR	Y N	HEPATITIS	Y N	PREGNANCY	Y N
RHEUMATIC FEVER	Y N	SICKLE CELL ANEMIA ...	Y N	TUBERCULOSIS	Y N
- IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? Y N IF YES, PLEASE LIST: _____
- PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS / SURGERIES / MAJOR ILLNESSES: _____
- DOES YOUR CHILD HAVE A HISTORY OF ALLERGIES / SENSITIVITIES / ADVERSE REACTIONS TO ANY DRUGS OR MEDICATIONS? Y N IF YES, PLEASE EXPLAIN: _____
- DOES YOUR CHILD HAVE A HISTORY OF ALLERGIES TO ANY OTHER SUBSTANCES (latex, environmental, etc)? Y N IF YES, PLEASE EXPLAIN: _____
- PLEASE DESCRIBE ANY OTHER MEDICAL CONCERNS YOUR CHILD HAS: _____
- CHILD'S PHYSICIAN: _____ PHONE: _____

I certify that all of the above information is correct to the best of my knowledge. I understand that providing incorrect health information may be harmful to my child. I understand that I must inform *Charleston Smiles* of any changes in my child's health history at subsequent appointments. If applicable, I authorize my child's dental insurance company to pay *Charleston Smiles* for services rendered. I also understand that insurance carriers sometimes pay less than the actual bill and I agree to be responsible for payment of all services not paid by insurance.

SIGNATURE OF PATIENT / PARENT / GUARDIAN

DATE

SIGNATURE OF DENTIST

DATE