Welcome To Growing Smiles Pediatric Dentistry!

HEALTH FORM

PATIENT'S DENTAL HISTORY

PATIENT'S NAME DOB

WHAT IS THE PRIMARY PURPOSE OF TODAY'S VISIT?

IS THE PATIENT CURRENTLY IN PAIN?

☐ YES ☐ NO

HAS THE PATIENT EVER HAD ANY PAIN/TENDERNESS OR ANY INJURY/SURGERY IN HIS/HER JAW JOINT (TMJ/TMD)?

☐ YES ☐ NO

HAS THE PATIENT EXPERIENCED PROBLEMS WITH PREVIOUS DENTAL WORK?

☐ YES ☐ NO

IS THE PATIENT'S WATER FLUORIDATED?

☐ YES ☐ NO

DOES THE PATIENT BRUSH AND FLOSS HIS/HER TEETH DAILY?

BRUSH ☐ YES ☐ NO FLOSS ☐ YES ☐ NO

NAME OF PATIENT'S PREVIOUS/REFERRING DENTIST

DATE OF LAST VISIT TO DENTIST

DESCRIBE PATIENT'S BEHAVIOR

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO THE PATIENT CURRENTLY:

- ☐ LIP SUCKING/BITING
- ☐ TONGUE/CHEEK BITING
- ☐ PACIFIER
- ☐ CHEWING ON OBJECTS
- ☐ TONGUE THRUST
- ☐ THUMB/FINGER SUCKING
- ☐ CLENCH/GRIND TEETH
- ☐ NAIL BITING
- ☐ SPEECH PROBLEMS
- ☐ MOUTH BREATHER
- ☐ NURSING/BOTTLE HABITS
- ☐ BREAST FEEDING

MEDICAL HISTORY

PATIENT'S PHYSICIAN

PHONE DATE OF LAST VISIT

IS THE PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN?

☐ YES ☐ NO IF YES, FOR WHAT CONDITION?

DESCRIBE THE PATIENT'S CURRENT PHYSICAL CONDITION:

☐ GOOD ☐ FAIR ☐ POOR

ARE THE PATIENT'S IMMUNIZATIONS CURRENT?

☐ YES ☐ NO

PLEASE LIST ALL DRUGS THE PATIENT IS CURRENTLY TAKING:

PLEASE LIST ALL DRUGS THAT MAY CAUSE AN ALLERGIC REACTION:

IS THERE ANYTHING THAT YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR IN PRIVATE?

☐ YES ☐ NO

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HEALTH FORM

PATIENT'S NAME DOB

MEDICAL HISTORY (CONTINUED)

PLEASE INDICATE IF THE PATIENT HAS/HAD ANY OF THE FOLLOWING:

- ☐ ABNORMAL BLEEDING
- ☐ ANY HOSPITALIZATION
- ☐ CHICKEN POX
- ☐ EPILEPSY
- ☐ TUBERCULOSIS
- ☐ HIVES
- ☐ LUPUS
- ☐ RHEUMATIC FEVER
- ☐ ADD/ADHD
- ☐ ALLERGIES
- ☐ ASTHMA
- ☐ CONGENITAL HEART DEFECT
- ☐ HANDICAPS/DISABILITY
- ☐ HEMOPHILIA
- ☐ KIDNEY PROBLEMS
- ☐ MEASLES
- ☐ SCARLET FEVER
- ☐ AIDS/HIV
- ☐ BLOOD TRANSFUSION
- ☐ CONVULSIONS
- ☐ HEARING IMPAIRMENT
- ☐ HEPATITIS
- ☐ LIVER PROBLEMS
- ☐ SICKLE CELL ANEMIA
- ☐ ANEMIA
- ☐ CANCER
- ☐ DIABETES
- ☐ HEART MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ MONONUCLEOSIS
- ☐ SKIN RASH
- ☐ SENSORY DISORDER

☐ OTHER (PLEASE EXPLAIN)

FOR OFFICE USE ONLY:

KELLI HENDERSON, DDS
DATE MEDICAL/DENTAL HISTORY REVIEWED

REFERRAL INFORMATION

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

☐ ANOTHER PATIENT (PLEASE LIST)

☐ DENTIST/DENTAL OFFICE (PLEASE LIST)

- ☐ INTERNET/WEBSITE
- ☐ FACEBOOK
- ☐ DRIVE-BY
- ☐ OTHER (PLEASE LIST)

CONSENT FOR SERVICES

As a condition of your patient's treatment by Growing Smiles, LLC, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients/parents for the costs incurred in their care and financial responsibility on the part of each patient/parent must be determined before treatment. A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days.

State law requires that a parent or guardian consent to dental services. By signing below, I affirm to the best of my knowledge that the information given above is correct. I understand that providing incorrect or inaccurate information can be dangerous to the patient's health. I further understand that the information will be held in the strictest confidence and that it is my responsibility to immediately inform Growing Smiles, LLC of any changes in the patient's medical status. I authorize the dental staff at Growing Smiles, LLC to perform any necessary dental services that my patient may need. I understand that payment for services will be due on the date they are provided. I further grant permission to Growing Smiles, LLC, to telephone me at my home, cell phone or work to discuss matters related to this form.

PATIENT NAME

PRINT NAME OF PARENT/GUARDIAN RELATIONSHIP TO PATIENT

SIGNATURE OF PARENT/GUARDIAN DATE

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