Child Patient Information

Date:_____
Child's Name:_____
Child's School:_____Sports/Hobbies:_____
Birthdate: ____/____/____ Age_____ Sex:_____Male ____Female
Address:_____
Street City Zip

Parent or Guardian Name:_____ Phone:_____
Siblings' Names/Ages:_____
How did you hear about us? _____
Reason for the visit today? _____

Responsible Party Information

1.Name:_____
Address:_____
Street City State Zip

Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email address:_____
Social Security #:_____ Birthdate: ___/___/___ Relationship to patient:_____
Employer:_____City:_____ State:_____
Occupation:_____

2.Name:_____
Address:_____
Street City State Zip

Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email address:_____
Social Security #:_____ Birthdate: ___/___/___ Relationship to patient:_____
Employer:_____ Work Phone:_____
Occupation: _____
Parents' Marital Status: Single___ Married___ Widowed___ Separated___ Divorced___

Dental Insurance Information

Insured's Name:_____ Insured Social Security #:_____
Insurance Company:_____ Group No._____
Insurance Co. Address:_____ Phone No._____
Do you have orthodontic coverage? Yes___ No___
Do you have dual coverage? Yes___ No___
Insured's Name:_____ Insured Social Security #:_____
Insurance Company:_____ Group No_____
Insurance Co. Address:_____ Phone No._____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize Beautiful Smiles of NJ to release all information necessary to secure the payment of benefits. I assign directly to Beautiful Smiles of NJ all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature:_____ Date:_____

Emergency Information

Name of emergency contact:_____

Address:_____Phone:_____
Street City Zip

Medical History

Pediatrician's Name:_____ Date of Last Visit:_____

Address:_____Phone:_____
Street City Zip

Circle the medical conditions below that your child ever had or has been treated for:

Abnormal Bleeding
Allergies
ADD/ADHD
Anemia
Any Hospital Stays/Operations
Artificial Bones/Joints/Valves
Arthritis
Asthma
Bone disorders
Cancer or Tumors
Congenital Heart Defect
Diabetes
Epilepsy/Seizures
Handicaps/Disabilities
Heart Murmur
Hemophilia
Hepatitis
High Blood Pressure
HIV+/AIDS
Kidney Disorders
Liver Problems
Prosthetics
Rheumatic Fever
Scarlet Fever
Sickle Cell Disease/Traits
Radiation/Chemotherapy
Tuberculosis

Please describe any serious medical problems:_____

_____

_____

Please circle Yes or No (If Yes, please fill in the details)

Yes No Are the child's immunizations current?_____
Yes No Is the patient taking any medications? Please list_____
Yes No Is the patient allergic to any medications? _____
Yes No Is the patient allergic to latex/nickel/metals/plastic?_____
Yes No Has the patient reached puberty (menstruation, voice changes, facial hair)?_____

Dental History

General Dentist's Name:_____ Date of Last Visit:_____

Address:_____Phone:_____
Street City Zip

What specific concerns do you have regarding your child's teeth?

_____

_____

Please circle Yes or No (If Yes, please fill in the details)

Yes No Has the patient ever had a bad experience at the dentist?_____

Yes No Does the patient require antibiotics before teeth cleaning or other dental appointments?_____

Yes No Does the patient have any speech problems?_____

Yes No Does the patient breathe through his/her mouth?_____

Yes No Have the adenoids or tonsils been removed?_____

Yes No Any injuries to the teeth, mouth, face, or jaws?_____

Yes No Does the patient's lower jaw ever click or get sore (TMJ/TMD)?_____

Yes No Does the patient have trouble opening wide?_____

Yes No Does the patient grind or clench his/her teeth?_____

Yes No Have you ever been informed that the patient has missing or extra permanent teeth?_____

Yes No Has the patient ever lost or chipped any teeth?_____

Yes No Any type of thumb/finger or tongue thrust habit?_____

Yes No Has the patient ever been treated by an orthodontist? Is yes, who and when?_____

Yes No Does the patient gag during dental procedures?_____

Yes No Is the patient sensitive/self-conscious about his/her teeth?_____

Yes No Have any other family members received orthodontic treatment?_____