LONESTAR SMILES FOR KIDS

We sincerely welcome you and your child to our practice. In order for us to better understand your child, please complete this form as thoroughly as possible. Thank you.

Child's Name _____ **Nickname** _____

Date of Birth _____ **Age** _____ ☐ **Male** ☐ **Female** **Weight** _____

Primary Guardian Name _____ **Relationship to Child** _____
Date of Birth _____ **Social Security number** _____
Driver's License number _____ **Employer** _____
Home Address _____ **City** _____ **State** _____ **Zip** _____
Cell Phone _____ **Home Phone** _____ **Other Number** _____
Email Address _____ ***Documentation of dental consenter will be required where applicable.**

Secondary Guardian Name _____ **Relationship to Child** _____
Date of Birth _____ **Social Security number** _____
Driver's License number _____ **Employer** _____
Home Address _____ **City** _____ **State** _____ **Zip** _____
Cell Phone _____ **Home Phone** _____ **Other Number** _____
Email Address _____ ***Documentation of dental consenter will be required where applicable.**

Primary Doctor's name _____ **Specialist (if any)** _____

Please circle Yes or No to the following questions. (If Yes, please explain.)

Yes No Is the patient allergic to any medication or food? _____

Yes No Is the patient taking any medication? _____

Yes No History of a major illness? _____

Yes No Has the patient had any operations? _____

Yes No Has your child or any blood relatives ever had problems with general anesthesia? _____

Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	**Diabetes**	**Hepatitis/Liver Problems**	**Undergoing Radiation/Chemo**
Anemia	**Dizziness**	**Herpes**	**Tuberculosis**
Asthma/Lung Problems	**Epilepsy**	**High Blood Pressure**	**Tumor/Growths**
Bone Disorders	**GI Disorders**	**HIV/AIDS**	
Congenital Heart Defect	**Heart Problems**	**Kidney Problems**	
	Heart Murmur	**Nervous Disorders**	

Are there any medical conditions we have not mentioned that you feel we should be aware of?

_____

_____

Please name a person outside your home we may contact in case of an emergency?

Emergency Contact _____ **Phone** _____

Parent Signature _____ **Date** _____

Dental Health and Hygiene Record

Is this your child's first visit to our office? ☐ Yes ☐ No

If so, whom may we thank for referring you to our office? _____

Has your child been seen in any other dental office? ☐ Yes ☐ No

If so, whom should we contact for dental records? _____

Was your child's last dental exam successful? ☐ Yes ☐ No Were X-Rays obtained? ☐ Yes ☐ No

Has your child experienced any unfavorable reaction from any previous medical or dental care? If so, please explain.

_____

_____

Does your child have any mouth habits such as finger sucking? If so, please explain.

_____

Does your child brush every day? ☐ Yes ☐ No

Does your child floss every day? ☐ Yes ☐ No

Do you assist with brushing or flossing? ☐ Yes ☐ No

Is your child still breast or bottle feeding? ☐ Yes ☐ No

Are there any dental concerns you would like us to discuss during your child's dental visit?

_____

_____

Does your child have any siblings? (Please list them and circle those we have seen.)

_____

Would you like the front desk to assist you in setting up any siblings we have not seen? ☐ Yes ☐ No

Photo Consent

As a pediatric specialty office, Dr. Boling frequently offers continuing education for parents, children and others concerning oral health. We would like permission to take photos of your child's face and teeth.

I, _____ as legally responsible parent/guardian of, _____

give permission to Lonestar Smiles for Kids, Dr. Boling's office, to use my child's photo in any future promotional materials: dental photo albums, professional journals, or books (either in print or on the web). I understand that no direct profit will be made of my image.

☐ DECLINED

Signature of parent/guardian _____ Date _____