

Little Jaws Big Smiles Pediatric Dentistry

(315) 299-4681

Tansy Schoonmaker, DDS

Cosmina Nolan, DDS

Child's Last Name _____ First Name _____

Mailing Address _____

Social Security Number _____ Date of Birth _____ Gender M F

Home Phone Number _____

PARENT/GUARDIAN #1

Last Name _____ First Name _____

Mailing Address _____

Cell Phone _____ Home Phone _____

Social Security Number _____ Date of Birth _____

Occupation _____ Employer and Work Phone Number _____

Marital Status _____ Email _____

PARENT/GUARDIAN #2

Last Name _____ First Name _____

Mailing Address _____

Cell Phone _____ Home Phone _____

Social Security Number _____ Date of Birth _____

Occupation _____ Employer and Work Phone Number _____

Marital Status _____ Email _____

ALTERNATE EMERGENCY CONTACT

Name _____ Relation _____ Phone _____

Is there a custody arrangement for your child? Y N

*If there is a custody arrangement, please provide us with a copy of the paperwork

Signature of Parent of Guardian

| Signature | Name | Date |
|-----------|------|------|
|-----------|------|------|

| | |
|--|---|
| <input type="checkbox"/> Someone told me about the office Who was it? | <input type="checkbox"/> Referred by Dentist Dentist's Name: |
| <input type="checkbox"/> Print Ad/Magazine-Which? | <input type="checkbox"/> Referred by Pediatrician Pediatrician's Name: |
| <input type="checkbox"/> Google Search | <input type="checkbox"/> Saw office when I drove by |
| | <input type="checkbox"/> Other (please list) |

FINANCIAL INFORMATION

Primary Dental Insurance

Name of Insured _____
Relationship _____
S.S.N. _____ D.O.B _____
Employer _____
Insurance Co. _____
ID Number _____
Group # _____
Ins. Co. Address _____

Ins. Co. Phone _____

Secondary Dental Insurance

Name of Insured _____
Relationship _____
S.S.N. _____ D.O.B _____
Employer _____
Insurance Co. _____
ID Number _____
Group # _____
Ins. Co. Address _____

Ins. Co. Phone _____

Primary Medical Insurance

Name of Insured _____
Relationship _____
S.S.N. _____
Employer _____
Insurance Co. _____
ID Number _____
Employee # _____
Ins. Co. Address _____

Ins. Co. Phone _____

Secondary Medical Insurance

Name of Insured _____
Relationship _____
S.S.N. _____
Employer _____
Insurance Co. _____
ID Number _____
Employee # _____
Ins. Co. Address _____

Ins. Co. Phone _____

MEDICAL INFORMATION

Your Child's Physician: _____
Physician's Address: _____
Physician's Phone #: _____
Your child's last appointment (approximately): _____
Medical Specialist #1: _____ Specialty: _____
Address: _____ Phone #: _____

PHARMACY INFORMATION

Name: _____
Address: _____
Phone #: _____

Patient Name: _____ DOB: _____

Please check if your child has ever had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> BiPolar Disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Medicine Allergy | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Feeding Tube | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Defect | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Wheel Chair | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Prostheses | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Disabilities | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Shunts |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Speech Issues | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> STD |
| <input type="checkbox"/> PDD | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> HIV/AIDS |

Please take the time to further explain any of the above marked "Yes":

Does your child have any ALLERGIES? Y N

If yes, please list all allergies your child is allergic to: _____

Does your child need to take antibiotic premedication before dental appointments for any of the following reasons (prosthetic heart valve, heart transplant, congenital heart defect, joint replacement) or for any other reasons? Y N

List and explain any surgeries your child has had:

If there are any medical conditions, surgeries or disabilities not addressed above, please describe them here:

Please list any medications, vitamins or herbal supplements your child takes

| Medication | Dose | Frequency | Condition Treated |
|------------|------|-----------|-------------------|
|------------|------|-----------|-------------------|

| Medication | Dose | Frequency | Condition Treated |
|------------|------|-----------|-------------------|
|------------|------|-----------|-------------------|

I, the undersigned, have answered the above truthfully and to the best of my knowledge. I testify that the information is complete, but should there be any updates to my child's medical or personal information, I understand that it is my obligation to notify the office to amend my child's records. I hereby consent to allow Little Jaws Big Smiles to perform any necessary dental treatment on my child.

| | | |
|---------------------------|--------------|------|
| Parent/Guardian Signature | Printed Name | Date |
|---------------------------|--------------|------|

| | | |
|---------------------------|--------------|------|
| Parent/Guardian Signature | Printed Name | Date |
|---------------------------|--------------|------|

Patient Name: _____ **DOB:** _____

1. Does your child have any speech issues or difficulty speaking? No Yes
 - If so, which sounds? _____
 - Any speech delay? _____
 - Difficulty speaking fast? _____
 - Difficulty speaking when tired? _____
 - Any stuttering or lisping? _____
 - Any speech therapy? (If so, how long?) _____

2. Does your child have any difficulties eating? No Yes
 - Is he/she a picky eater? _____
 - Does he/she eat slowly? _____
 - Any certain textures difficult? _____
 - Any difficulty transitioning to solid foods? (Choking or gagging)? _____

3. Did your child have difficulty nursing or taking a bottle as a baby? (i.e. poor latch, poor weight gain, reflux, colic, painful nursing, poor supply) No Yes _____

4. Does your child have any TMJ, neck or shoulder pain? No Yes _____

5. Does your child have a strong gag reflex? No Yes _____

6. Does your child grind his/her teeth during the day or at night? No Yes _____

7. Does your child sleep restlessly? No Yes _____

8. Is there anything else that we need to know? No Yes _____