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**

☐Someone told me about the office Who was it?	☐Referred by Dentist Dentist's Name:
☐Message Board at JCC	☐Referred by Pediatrician Pediatrician's Name:
☐Print Ad/Magazine-Which?_____	☐T-Ball League
☐Google Search	☐Saw office when I drove by
☐Baby Expo	☐Other (please list)

How would you like for us to contact you remind you of appointments?
☐Home Phone ☐Cell Phone ☐Email ☐Text

Name:_____**DOB:**_____

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 #: _____

Name:_____**DOB:**_____

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

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

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

Does your child have any ALLERGIES to any medications? ☐ Y ☐ N
If yes, please list medications 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**

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