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:
☐Print Ad/Magazine-Which?	☐Referred by Pediatrician Pediatrician's Name:
☐Google Search	☐Saw office when I drove by
	☐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:

☐ 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? 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

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

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 _____