

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 _____

Signature of Parent or Guardian

Signature _____ Name _____ Date _____

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

Your Pharmacy's Name: _____

Address: _____

Phone Number: _____

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 _____

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

Name: _____ DOB: _____

Gender M F Pronouns: She/Her/Hers He/Him/His They/Them/Theirs Other: _____

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 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
_____ Doctor Signature	_____ Printed Name	_____ Date