SURFSIDE KIDS DENTAL

Today's Date: _____

Child's Name: _____ M/F Nickname: _____ DOB: _____/_____/_____

Will you be requesting a translator? ☐Yes ☐No **If yes, what language?** _____

Responsible Party #1

Name: _____ DOB: _____/_____/_____

Relationship to the child: ☐Biological Parent ☐ Step Parent ☐Foster Parent Are you a legal guardian? ☐Yes ☐ No

Marital Status: ☐Married ☐ Divorced ☐Single ☐Widowed

Address: _____
(City) (State) (Zip)

Cell#: _____ Work # _____ Ext: _____ Home #: _____

Social Security Number: _____ Occupation: _____

Email Address: _____

Responsible Party #2

Name: _____ DOB: _____/_____/_____

Relationship to the child: ☐Biological Parent ☐ Step Parent ☐Foster Parent Are you a legal guardian? ☐Yes ☐ No

Marital Status: ☐Married ☐ Divorced ☐Single ☐Widowed

Address: _____
(City) (State) (Zip)

Cell#: _____ Work # _____ Ext: _____ Home #: _____

Social Security Number: _____ Occupation: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship: _____

Cell#: _____ Work # _____ Ext: _____ Home #: _____

Primary Dental Insurance

☐No Insurance

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Birthdate: _____/_____/_____ Social Security Number: _____

Policy Holders Employer: _____

Insurance Company Name: _____ Group Number: (Plan, Local, or Policy #) _____

Insurance Company Phone Number: _____ Insurance Company Address: _____

Secondary Dental Insurance

If you have secondary insurance, does your child reside with you with you? ☐50% or ☐100% of the time?

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Birthdate: _____/_____/_____ Social Security Number: _____

Policy Holders Employer: _____

Insurance Company Name: _____ Group Number: (Plan, Local, or Policy #) _____

Insurance Company Phone Number: _____ Insurance Company Address: _____

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Pediatric Medical History

Child's Name: _____ M / F Birthday: _____/_____/_____

Race / Ethnicity: _____ Height: _____ Weight: _____ Date of last physical exam: _____

Name of Primary Physician or Specialists: _____ Phone: _____

Birth / Development

Complications	Yes	No
Prematurity	Yes	No
Birth defects	Yes	No
Syndromes	Yes	No
Inherited conditions	Yes	No
Developmental problems	Yes	No

Neurological / Physiological

Autism spectrum disorder	Yes	No
Sensory processing disorder	Yes	No
Impaired vision, hearing or speech	Yes	No
Developmental delay or intellectual disability	Yes	No
Cerebral palsy or brain injury	Yes	No
Epilepsy or seizures	Yes	No
Vagal nerve stimulator	Yes	No
Frequent headaches or fainting	Yes	No
Hydrocephaly or shunt (VP, VA, VV)	Yes	No
ADD/ADHD	Yes	No
Behavioral or psychiatric problems	Yes	No
Depression	Yes	No
Anxiety	Yes	No

Heart

Congenital heart defect	Yes	No
Heart murmur	Yes	No
Rheumatic heart disease	Yes	No
Irregular heart beat	Yes	No
High blood pressure	Yes	No
Heart surgery	Yes	No

Blood

Hemophilia or other bleeding disorder	Yes	No
Anemia	Yes	No
Sickle cell trait/disease	Yes	No
Blood transfusion	Yes	No
Frequent nosebleeds	Yes	No

Head & Neck / Sleep

Sinusitis	Yes	No
Tonsil / adenoid infections	Yes	No
Snoring	Yes	No
Sleep apnea	Yes	No
Had a sleep study	Yes	No
Cleft lip and/or palate	Yes	No

Respiratory

Asthma	Yes	No
Frequent colds or coughs	Yes	No
Bronchitis or pneumonia	Yes	No
Tuberculosis (TB)	Yes	No
Cystic fibrosis	Yes	No

Musculoskeletal

Artificial joint	Yes	No
Arthritis	Yes	No
Limited use of arms/ legs	Yes	No
Scoliosis / lordosis / kyphosis	Yes	No

Infectious Disease

HIV/AIDS	Yes	No
Airborne illnesses	Yes	No

Digestive

Over- or underweight	Yes	No
Hepatitis or liver problems	Yes	No
GERD or acid reflux	Yes	No
Stomach ulcers	Yes	No
Gluten sensitivity	Yes	No
Other dietary restrictions	Yes	No

Cancer History

Leukemia	Yes	No
Tumor	Yes	No
Radiation	Yes	No
Chemotherapy	Yes	No
Organ transplant	Yes	No

Bladder or kidney problems	Yes	No
Eczema or other skin problems	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid or pituitary problems	Yes	No
Precocious puberty or other hormonal problems	Yes	No

Family History

Malignant hyperthermia (MH)	Yes	No

Females Only

Is there any chance you could be pregnant?	Yes	No

Allergy to any of the following: ☐Latex ☐Nickel/silver ☐Dental anesthetic ☐Sedatives ☐Soy ☐Egg yolk ☐Tree nuts ☐Milk protein ☐None

☐ Yes ☐No Allergies to any foods or medications? List: _____

☐ Yes ☐No Is your child taking any medications? List: _____

☐ Yes ☐No Are your child's immunizations up-to-date? _____

☐ Yes ☐No Has your child been ever treated in an emergency room? List: _____

☐ Yes ☐No Has your child ever been hospitalized? List: _____

☐ Yes ☐No Has your child ever had surgery, including dental surgery? List: _____

☐ Yes ☐No Is there anything on your child's medical, dental or family history that the dentist should be aware of? List: _____

* I authorize the following dental procedures for my child: a cleaning, x-rays and/or fluoride application, if advised. * Initial: _____

Signature: _____ Relationship to child: _____ Legal guardian? ☐Yes ☐ No Date: _____

Dentist's notes: _____

_____

_____

Dentist signature: _____ Date: _____

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