Welcome to

GROWING SMILES LLC.

211 West Millstream Road Cream Ridge, NJ 08514 (609) 758-9595 (609) 758-9594 fax

1. About Your Child

Today's Date: _____/_____/_____

Child's Name:_____ Nickname: _____

Child's Birthdate: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

School:_____ Grade: _____

Child's Home Phone #(____)_____ Child's SS#_____

Child's Address:_____
street

_____
city state zip

Child Lives with: ☐ both parents ☐ mother ☐ father ☐ other_____

How did you hear about us?: _____

2. Child's Family Information

Who is accompanying this child today?

_____ _____
Full Name Relationship to Child

Do you have legal custody of this child? ☐ Yes ☐ No

Other siblings (with age) _____

Mother's Information

Name: _____ ☐ mother ☐ step mother ☐ guardian

☐ check if same as child Home Address:_____
street

_____
city state zip

_____
home phone # cell phone # other phone #

_____
email address

_____ _____/_____/_____ _____
Mother's Social Security # Mother's Date of Birth Mother's Drivers Lic. #

Employer:_____ How Long? _____

Employer's Address _____
city state zip phone number

Father's Information

Name: _____ ☐ father ☐ step father ☐ guardian

☐ check if same as child Home Address: _____
street

_____
city state zip

_____
home phone # cell phone # other phone #

_____
email address

_____ _____/_____/_____ _____
Father's Social Security # Father's Date of Birth Father's Drivers Lic. #

Employer: _____ How Long? _____

Employer's Address _____
city state zip phone number

3. Insurance Information

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's SS #: _____

Group # (Plan, Local, or Policy #): _____

Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

4. Responsible Party

I understand and agree that regardless of my insurance status, I am financially responsible for the full payment of fees at the time that professional services are rendered unless prior arrangements have been made or Growing Smiles accepts my insurance as form of payment. I certify that the above information is true and correct to the best of my knowledge.

Name: _____
print relation to child signature

In the event of an emergency and I am not able to accompany my child, I give consent to Dr. Roeder and staff to provide any necessary immediate treatment.

Name: _____
print relation to child signature

GROWING SMILES LLC.

Patient Name:_____ ***Nickname:***_____

Date of Birth:_____ ***Patient Gender:*** ☐ ***Male*** ☐ ***Female***

Child's Medical History

Has the child had any history of difficulty with or diagnosis of any of the following?

Please **circle** ***YES*** **or** ***NO*** as appropriate.

ADD/ADHD/Hyperactivity	*Yes*	*No*	Hearing Impairment	*Yes*	*No*	Seizures	*Yes*	*No*
Asthma	*Yes*	*No*	Heart Condition/Disease	*Yes*	*No*	Sinus Problems	*Yes*	*No*
Autism/ASD	*Yes*	*No*	Hepatitis	*Yes*	*No*	Speech Impairment/Condition	*Yes*	*No*
Bleeding Disorder/Condition	*Yes*	*No*	HIV/AIDS	*Yes*	*No*	Stomach Problems/Condition	*Yes*	*No*
Diabetes	*Yes*	*No*	Kidney Disease	*Yes*	*No*	Tuberculosis	*Yes*	*No*
Down Syndrome	*Yes*	*No*	Radiation Treatment	*Yes*	*No*	Thyroid Condition/Disorder	*Yes*	*No*
Growth Problems	*Yes*	*No*	Rheumatic Fever	*Yes*	*No*	Other:_____	*Yes*	*No*

Name of child's physician:_____ Phone # of physician:_____

Child's approximate weight:_____lbs. Child's general health ☐ good ☐ fair ☐ poor

Current medications:_____

Are immunizations up to date? ☐ No ☐ Yes

Is the child allergic to any medications? ☐ No ☐ Yes _____

Is the child allergic to anything else such as latex, certain foods, dyes, etc? ☐ No ☐ Yes _____

Has the child had any surgeries? ☐ No ☐ Yes _____

Does the child have a physical, mental or emotional impairment or condition? ☐ No ☐ Yes _____

Is the child being treated for anything at this time? ☐ No ☐ Yes_____

Both doctor and patient and/or parent/guardian are encouraged to discuss any and all relative patient health issues prior to treatment. Is there anything you'd like to discuss with the doctor in private? ☐ No ☐ Yes

GROWING SMILES LLC.

Patient Name:_____

Child's Dental History

Does the child have or had any of the following?

Please **circle** ***YES* or *NO*** as appropriate.

Pacifier, Thumb or Finger Sucking	*Yes*	*No*
Nail Biting/Chewing on Objects	*Yes*	*No*
Mouth Breather	*Yes*	*No*
Snoring	*Yes*	*No*

Dental Trauma/Injury to Mouth or Teeth	*Yes*	*No*
Clenching or Grinding	*Yes*	*No*
Bottle or Breastfed at Bedtime Past One Year of Age	*Yes*	*No*
Bad Breath	*Yes*	*No*

Is this the child's first dental visit? ☐ No ☐ Yes

If you checked No, please answer the following:

Previous Dentist:_____ Phone Number:_____

Date of Last Dentist Visit:_____

Were x-rays taken? ☐ No ☐ Yes ☐ Don't Know

Has the child ever had a negative dental experience? ☐ No ☐ Yes _____

At approximately what age did the child's first baby tooth erupt?_____

Does the child require antibiotic pre-medication prior to dental treatment? ..... ☐ No ☐ Yes ☐ Don't Know

Does the child have a "sweet" tooth? ..... ☐ No ☐ Yes

Does the child snack frequently? ..... ☐ No ☐ Yes

Is the child taking fluoride supplements (tablets or drops)?..... ☐ No ☐ Yes

Is the child's drinking water fluoridated? ..... ☐ No ☐ Yes ☐ Don't Know

How would you rate the child's oral hygiene/health? ..... ☐ Good ☐ Fair ☐ Poor

The purpose of today's visit (check all that apply):. ☐ Routine Cleaning/Checkup ☐ Emergency/Pain ☐ Initial/First Dental Exam ☐ Second Opinion

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I understand that all information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's status. I authorize the dental team at Growing Smiles to perform any necessary dental service for my child.

_____ Signature

_____ Please print name and relationship to patient.

_____ Date