301 Oxford Valley Rd. Suite #1801
Yardley, PA 19067
Phone: 267-392-5878

2842 Street Rd
Bensalem, PA 19020
Phone: 215-433-1840

SeaOfSmilesPA.com

DATE:_____

Patient Information

Name _____ Nickname _____ Sex **M** **F**
Last First Middle

Address _____
Street City Zip

Age _____ Birthdate _____/_____/_____ School _____ Grade _____

Sports/Hobbies/Interests _____

Siblings _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle

Address _____
Street City State ZIP

Home Phone _____ Cell Phone _____ Preferred Contact **Home** **Cell**

Email Address _____

Relationship to Patient _____ SS # _____ Occupation _____

Birthdate _____/_____/_____ Employer _____Work Phone _____

Marital Status **Single** **Married** **Divorced** **Adoptive Parent** **Foster Parent**

Significant Other's Name _____

Relationship to Patient_____ SS # _____ Occupation _____

Birthdate _____/_____/_____ Employer _____ Cell Phone _____

Dental Insurance Information

Policy Owners Name _____ Policy Owner's SS# _____

Policy Owner's Birthdate _____/_____/_____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Company Address _____

Do you have dual coverage? **YES** **NO** If Yes:

Policy Owners Name _____ Policy Owner's SS# _____

Policy Owner's Birthdate _____/_____/_____ Relationship to Patient _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Company Address _____

Medical History

Has your child ever had any of the following conditions?

Y N Asthma/Lung Troubles
Y N Anemia
Y N Allergies to Drugs/Foods
Y N Austim/Asperger's
Y N Behavior Issues (ADD/ADHD)
Y N Blood Disorders
Y N Cancer
Y N Cong. Birth Defects
Y N Diabetes
Y N Disabilities/Special Needs
Y N Epilepsy or Seizures
Y N Hearing Impairment
Y N Heart Conditions/Murmur
Y N Hepatitis/HIV/AIDS
Y N Hospitalizations/ Surgeries
Y N Kidney/Liver Conditions
Y N Neurological Conditions
Y N Pregnancy
Y N Premature Birth
Y N Tuberculosis

If **YES**, please explain _____

Please list all drugs/medications the child is currently taking _____

Child's Physician _____ Phone Number _____

Dental History

Is this your child's first visit to the dentist? **YES** or **NO**

If No, where and when was your child last seen? _____

Were any X-rays taken at previous dental visits? **YES** or **NO**

Has your child ever had a traumatic experience at the dental office? _____

Any questions or concerns about your child's teeth? _____

Any of the following habits?

Y N	Frequent snacking	**Y N**	Night-time feeding
Y N	Lip Sucking / Biting	**Y N**	Nail Biting
Y N	Sleeping with a bottle	**Y N**	Thumb/Finger Sucking
Y N	Tooth Grinding	**Y N**	Snoring
Y N	Sippy Cup Use	**Y N**	Pacifier Use

Does your child brush his/her own teeth? **YES** **NO**

How often? _____ x a day

Do you floss his/her teeth? **YES** **NO**

Is your child able to spit? **YES** **NO**

What kind of toothpaste do you use? _____

ACKNOWLEDGEMENT AND AUTHORITY

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before services can be rendered. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICE AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

_____

Signature of Parent or Guardian Date Relationship to Child

_____

Doctor Signature Date