smiley
family dentistry p.c.

Colette R. Smiley, D.D.S.
Christopher J. Smiley, D.D.S.
Stephanie M. Benton, D.D.S.

3299 Clear Vista Ct., N.E. Suite A Grand Rapids, Michigan 49525 616 361 0654 www.smileydds.com

PEDIATRIC PATIENT REGISTRATION

CHILD'S NAME _____
LAST FIRST INITIAL

NICKNAME _____

RESIDENCE: STREET _____

CITY _____ STATE _____ ZIP _____

TELEPHONE _____

APPOINTMENT CONFIRMATION NUMBER _____

PARENT'S EMAIL ADDRESS _____

CHILD'S SOCIAL SECURITY NUMBER _____

AGE _____ WEIGHT _____

☐ MALE ☐ FEMALE

SCHOOL OR DAYCARE NAME _____

NAME OF SIBLINGS _____

NAME OF PET/FRIEND _____

DATE _____ DATE OF BIRTH _____

SPORTS OR ACTIVITIES _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

EMERGENCY CONTACT _____

PAYMENT POLICY

Patients are asked to settle their accounts at the time of service. We accept Master Card, Visa, and Discover, and for more extensive treatment we are willing to extend payment plans.

Our office will complete and submit most types of dental insurance claim forms. Please remember that insurance is a method of reimbursing the patient for dental expenses. Because insurance is a contract between the patient and their employer or insurance company, the responsibility for payment of the account is your direct obligation.

CANCELLATION POLICY

If you have to reschedule or cancel an appointment, please give us at least 48 hours notice. Patients who cancel without informing us beforehand may be billed for their missed appointment and repeated cancellations may result in a patient not being rescheduled.

WE ARE COMMITTED TO PROVIDING YOU WITH QUALITY DENTAL CARE. WHAT ARE YOUR EXPECTATIONS FOR YOU AND YOUR FAMILY'S DENTAL CARE?

MEDICAL DENTAL HISTORY

PATIENT'S NAME _____
LAST FIRST INITIAL DATE OF BIRTH

MEDICAL HISTORY:

CHILD'S PEDIATRICIAN _____

ADDRESS _____

PHONE _____

DATE OF LAST EXAM _____

ANY PRESENT ILLNESS? _____

CURRENT MEDICATIONS TAKEN _____

ALLERGIES OR ADVERSE REACTIONS TO ANY MEDICATIONS? _____

_____

_____

_____

ALLERGY TO LATEX PRODUCTS? _____

ANY OTHER ALLERGIES? _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

- ☐ ADD/ADHD
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ AUTISM
- ☐ BLEEDING DISORDER
- ☐ COLD/CANKER SORES
- ☐ DIABETES
- ☐ EMOTIONAL PROBLEMS
- ☐ EPILEPSY/CONVULSIONS
- ☐ FAINTING OR DIZZINESS
- ☐ HEARING PROBLEM
- ☐ HEART PROBLEM
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HIV/AIDS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL DISORDER
- ☐ RHEUMATIC FEVER
- ☐ SLEEP APNEA
- ☐ TUBERCULOSIS
- ☐ TUMORS/CANCER
- ☐ SPECIAL NEEDS/OTHER:

_____

_____

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE OR OTHER PROBLEMS NOT LISTED:

_____

_____

DENTAL HISTORY:

PURPOSE OF TODAY'S VISIT _____

_____

PREVIOUS DENTIST _____

DATE OF LAST DENTAL VISIT/LAST XRAYS _____

HAS YOUR CHILD SEEN THE ORTHODONTIST? _____

NAME OF ORTHODONTIST _____

LAST ORTHODONTIC VISIT _____

HAS YOUR CHILD HAD DIFFICULTY WITH PREVIOUS DENTAL VISITS? _____

_____

HOW OFTEN DOES YOUR CHILD BRUSH? _____

HOW OFTEN DOES YOUR CHILD FLOSS? _____

DOES YOUR CHILD:

TAKE FLUORIDE SUPPLEMENTS? _____

USE A PACIFIER? _____

SUCK THUMB OR FINGER? _____

SUCK OR BITE LIP? _____

BITE OR CHEW NAILS? _____

GRIND TEETH? _____

CLENCH JAWS? _____

GAG EASILY? _____

HAVE A HISTORY OF INJURY TO MOUTH OR TEETH? _____

SENSITIVE OR PAINFUL TEETH? _____

DRINK CITY OR WELL WATER? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

_____
PARENT'S SIGNATURE DATE