Welcome

About Your Child

_____
Child's Full Name

_____ ❑ M ❑ F _____
Age Date of Birth

Reason for Visit _____

_____

_____

Referred To This Office By:

_____
Full Name

_____
Phone Number

Dental History

Child's First Dental Visit? ❑ Yes ❑ No

_____
Previous Dentist City

_____
Date of Last Visit Date of Last X-rays

Any injuries to the teeth or jaws? ❑ Yes ❑ No

If yes, when _____

Does your child receive:
❑ Gummy Vitamins
❑ Fluoride in vitamins
❑ Fluoride tabs/drops
❑ Fluoridated water
❑ None

Has your child experienced any unfavorable reaction from previous medical or dental care? ❑ Yes ❑ No

If yes, explain _____

_____

_____

How do you think your child will act towards the dentist?

_____

Growing Smiles in Floral Vale

Pediatric Dentistry by
Dr. Sheryl Radin
Dr. Ross Levine

808 Floral Vale Boulevard
Yardley, PA 19067
(215) 860-9808
www.growingsmilespa.com

Medical History

_____
Child's Physician/Pediatrician's Name

_____
Phone Number

Is your child presently under the care of a specialist for any medical reason? ❑ Yes ❑ No

If yes, what? _____

_____

_____
Specialist's Name Phone Number

	Yes	No
Does your child have a history of health problems? If yes, explain?_____	❑	❑
Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt or other medical reason?	❑	❑
Is your child presently taking any medications? If yes, explain?_____	❑	❑
Has your child had a history of taking frequent medications? If yes, explain?_____	❑	❑
Has your child been hospitalized or had surgery? If yes, explain?_____	❑	❑
Is your child allergic to any drugs? If yes, explain?_____	❑	❑
Is your child allergic to any foods? If yes, explain?_____	❑	❑
Is your child allergic to any medications or dyes? If yes, explain?_____	❑	❑
Is your child allergic to any environmental pollutants? If yes, explain?_____	❑	❑
Is your child allergic to any latex, metals or acrylics? If yes, explain?_____	❑	❑
Has any family member, including your child had a problem with general anesthetic? If yes, explain?_____	❑	❑

Has your child ever been diagnosed as having any of the following conditions? Please check Yes or No.

Y	N		Y	N	
❑	❑	ADHD/ADD	❑	❑	Excessive Bleeding Problem
❑	❑	Aids/HIV	❑	❑	Excessive Gagging
❑	❑	Anemia	❑	❑	Fainting or Dizziness
❑	❑	Arthritis	❑	❑	Fever Blisters
❑	❑	Asthma - What triggers it?	❑	❑	Growth/Developmental Problems
❑	❑	Autism	❑	❑	Heart Surgery
❑	❑	Bladder Conditions	❑	❑	Headaches
❑	❑	Blood Disease	❑	❑	Hearing/Speech Impairments
❑	❑	Blood Transfusions	❑	❑	Heart Murmur/Defects
❑	❑	Birth Defects	❑	❑	Hemophilia
❑	❑	Bone or Joint Problems	❑	❑	Hepatitis/Liver Disease
❑	❑	Brain Injury	❑	❑	High Blood Pressure
❑	❑	Bruising Easily	❑	❑	Kidney Disease
❑	❑	Cancer or Malignancies	❑	❑	Leukemia
❑	❑	Cerebral Palsy	❑	❑	Mental Disability
❑	❑	Chemotherapy/Radiation	❑	❑	Mouth Sores
❑	❑	Child Abuse	❑	❑	Nutritional Deficiency
❑	❑	Chronic Adenoid/Tonsil Infections	❑	❑	Orthopedic Problems
❑	❑	Chronic Ear Infections	❑	❑	Pain in Jaw Joints
❑	❑	Cleft Lip/Palate	❑	❑	Premature Birth
❑	❑	Congenital Heart Lesion	❑	❑	Psychiatric Care
❑	❑	Convulsions/Seizures	❑	❑	Rheumatic Fever
❑	❑	Developmentally Delayed	❑	❑	Scoliosis
❑	❑	Diabetes	❑	❑	Sickle Cell Anemia
❑	❑	Drug Addiction	❑	❑	Syndrome_____
❑	❑	Ear Stuffiness, Itching or Noises	❑	❑	Tuberculosis
❑	❑	Emotional Disturbance	❑	❑	Other _____
❑	❑	Epilepsy	❑	❑	Do you wish to talk to the doctor privately about a special concern?
❑	❑	Eye Problems			

PLEASE COMPLETE BOTH SIDES OF THIS FORM. THANK YOU

Responsible Party Parent/Guardian

Father/Guardian Full Name

Address

City State Zip

SS# Birth Date

Home Phone # Business Phone #

Cell Phone # Email Address

Employer Occupation

Mother/Guardian Full Name

Address

City State Zip

SS# Birth Date

Home Phone # Business Phone #

Cell Phone # Email Address

Employer Occupation

Is patient living with both parents? ❑ Yes ❑ No

If no, with whom does the child reside? _____

Siblings

Name Birth Date

Name Birth Date

Name Birth Date

Nearest Relative/Friend

Name

Address

Phone

Relationship

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Dental Insurance Information

Primary Dental Insurance Group #

Policy Holder Name

Secondary Dental Insurance Group #

Policy Holder Name

Consent For Treatment

I am the (parent/guardian) of _____ (name of child) who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Dr. Sheryl Radin and Dr. Ross Levine. This includes exposure of radiographs as necessary, use of local anesthesia, inhalation and oral medication, responsible restraint as needed and use of appropriate medicaments and materials for such treatment. If I have any objections to certain aspects of treatment, I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.

Parent/Guardian Signature

Date

PLEASE NOTE: Payment is expected for service rendered at the time of treatment. If the family is not living together the parent bringing the child is responsible for the child's account.

School Information

Name of Preschool or Elementary School your child attends or will attend: