105 North Dean Street
Englewood, NJ 07631
growingsmilesnj.com

Office: 201-608-5114
Fax: 201-608-5204
info@growingsmilesnj.com

Growing Smiles Of Englewood

Patient Information

Child's Name: ______________________ Nickname: __________ Date of Birth: ________
Last First MI

Gender: Male Female Phone (Home): ______________________

Address: ____
Street City State Zip Code

Name of Pediatrician: ______________________ Phone: ______________________

Parent Information

Mother's Name: ______________________ Cell Phone #: ______________________
Last First MI

Mother's Social Security #: ______________________ Work Phone #: ______________________

Address (if different from above): ____
Street City State Zip Code

Father's Name: ______________________ Cell Phone #: ______________________
Last First MI

Father's Social Security #: ______________________ Work Phone #: ______________________

Address (if different from above): ____
Street City State Zip Code

Preferred Method of Contact: ____
Email Phone

Health Information

Please review carefully and check if your child had any history of, or condition related to, any of the following:

- ☐ ADHD / ADD
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Enlarged Tonsils
- ☐ Epilepsy / Seizures
- ☐ Fainting
- ☐ Growth Problems
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ HIV+ / AIDS
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver / Hepatitis
- ☐ Measles
- ☐ Mononucleosis
- ☐ Pregnancy (teens)
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Speech / Hearing
- ☐ STD
- ☐ Thyroid
- ☐ Tobacco / Drug Use
- ☐ Tuberculosis
- ☐ Vision Disorder

OTHER:
☐ __________________

Health and Dental History:

Yes No

1. Reason for this visit: ____
2. ☐ ☐ Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?
   If yes, please list all: ____
3. ☐ ☐ Is your child allergic to (if yes, please explain):
   a. any medications: ____
   b. any foods: ____
   c. any metals / latex: ____
   d. seasonal / other: ____
4. ☐ ☐ Has your child ever been hospitalized or had any type of surgery?
   Please explain: ____
5. ☐ ☐ Has your child ever received sedation or general anesthesia?
6. ☐ ☐ If yes to previous, has your child had any complications with sedation or general anesthesia?
   Please explain: ____
7. ☐ ☐ Does your child have any mental, developmental or physical impairment?
   Please explain: ____
8. ☐ ☐ Has your child ever experienced excessive bleeding when cut or injured?
9. ☐ ☐ Does your child have any genetic or inherited disorders?
   Please explain: ____

Yes No

☐ ☐ 10. Is your child being treated for any other illnesses not yet discussed on this form?
Please explain: ____________________

☐ ☐ 11. Are your child's immunizations up to date? If not, please explain: ____________________

☐ ☐ 12. Is this your child's first dental visit? If not, date of last visit: ____________________

☐ ☐ 13. Has your child ever had an unfavorable experience or reaction to a previous dental visit?
Please explain: ____________________

☐ ☐ 14. Have there been any injuries to your child's mouth, teeth, or head?
Please explain: ____________________

☐ ☐ 15. Does your child take fluoride supplements?

☐ ☐ 16. Is fluoride toothpaste used?

☐ ☐ 17. How often are your child's teeth brushed per day? _______ What time of day are they brushed? _________

☐ ☐ 18. Is the brushing supervised and / or assisted?

☐ ☐ 19. Does your child participate in any sports or other active recreational activities?

☐ ☐ 20. Has your child complained of any recent dental pain?
Please explain: ____________________

☐ ☐ 21. Any other dental concerns / comments not yet discussed on this form? ____________________

Please answer the following questions regarding past and current feeding and other habits:

	Past	Current	N/A
Breast-Feeding Age when stopped ______	☐	☐	☐
Bottle Use Contents ____________ Age when stopped _____	☐	☐	☐
Sippy cup use Contents ____________ Age when stopped _____	☐	☐	☐

	Past	Current	N/A
Thumb/finger sucking Age when stopped _______	☐	☐	☐
Pacifier use Age when stopped _______	☐	☐	☐
Teeth grinding/clenching Age when stopped _______	☐	☐	☐

Referral Information

Whom may we thank for referring you to our practice? ☐ Another Patient ☐ Dental Office ☐ Google ☐ School
☐ Work ☐ Other ____________________

Dental Insurance Information

Insurance Company Name: ____________________ ID #: ____________________

Group #: ______________ Policy Owner's Name: ____________________
Last First MI

Date of Birth: ______________ Relationship to child: ____________________

Employer: ____________________

Address: ____________________
Street City State Zip Code

As this child's parent or legal guardian, I acknowledge that the information in this form is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment. Consent for treatment: Payment is due on the day services are rendered. Please keep in mind that you are ultimately responsible for any outstanding balance. Any estimate of your portion of payment is only an estimate and is not a guarantee of what your insurance company will pay. You may be sent a bill for the remaining balance of what was not covered by insurance.

____________________ ____________________ ____________________
Signature of parent or guardian Print Name Today's Date

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Patient HIPAA Awareness

With my permission, Growing Smiles of Englewood may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Growing Smiles of Englewood Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Growing Smiles of Englewood reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Growing Smiles of Englewood may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out PTO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Growing Smiles of Englewood may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

With my permission, the office of Growing Smiles of Englewood may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Growing Smiles of Englewood restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Growing Smiles of Englewood to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____
Signature of Patient or Legal Guardian

____ _______________________
Print Name of Patient or Legal Guardian Date