KIDS' SMILES ON LINCOLN
Pediatric Dentistry

Child's Name:_____ Preferred Name:_____

Sex: Male / Female DOB:____/____/_____ Age:_____ School: _____**Mother's Name**

(First, Last)_____

SSN:____-____-____ DOB:____/____/____ Driver's License #:_____

Father's Name (First, Last)_____

SSN:____-____-____ DOB:____/____/____ Driver's License #: _____

Child's Address:_____ Unit/Apt#_____

City:_____ State:_____ Zip:_____Phone#:____-____-_____

Text Apt Reminders:____-____-_____ **Email:**_____

How did you hear about us?_____

Let's Be Friends! Facebook:_____ **Instagram**:_____

Consent of a Parent/Guardian is necessary for dental treatment of a minor. I give permission for dentists of Simply Dental & Orthodontics to use diagnostic measures deemed necessary in his/her professional judgement to render the best dental treatment to my child. This may include but is not limited to an oral evaluation, cleaning, dental x-rays, and/or fluoride application at the time of an initial visit, routine visit or consultation. The information I have given is accurate to the best of my knowledge and it will be held in the strictest of confidence according to HIPPA laws and regulations. It is my responsibility to inform the dentist of any changes to my child's health status.

Initials:_____ Signature:_____ Date:____/____/____

Financially Responsible Person (First, Last):_____

Billing Address:_____Unit/Apt#_____

City:_____ State:_____ Zip:_____ Phone#:____-____-_____

Email Address:_____

Emergency Contact:_____ Phone #_____

Primary Dental Insurance:_____Member ID#_____

Group #:_____

Card Holder's Name:_____Relationship to child:_____

SSN #:____-____-_____ DOB:____/____/_____

Employer:_____Work #:_____

Secondary Dental Insurance:_____Member ID#_____

Group #:_____

Card Holder's Name:_____Relationship to child:_____

SSN #:____-____-_____ DOB:____/____/_____

Employer:_____Work #:_____

Pediatric Medical History

Child's legal name: _____ **Nickname:** _____ **Date of birth:** _____/_____/_____
Birth sex: ❑ M ❑ F **Current gender identity:** _____ **Pronouns:** _____ **Race/Ethnicity:** _____ **Height:** ____cm **Weight:** ____kg
Name/age and relationship of others living in the household: _____
_____
Primary physician: _____ **Address/phone:** _____ **Last visit:** _____
Medical specialists: _____ **Address/phone:** _____ **Last visit:** _____

Is your child being treated by a physician at this time? Reason _____ ❑ YES ❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ..... ❑ YES ❑ NO
List name, dose, frequency & date started: _____
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ..... ❑ YES ❑ NO
List date & describe: _____
Has your child ever had a reaction to or problem with an anesthetic? Describe _____ ❑ YES ❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ ❑ YES ❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ ❑ YES ❑ NO
Is your child up to date on immunizations against childhood diseases? ..... ❑ YES ❑ NO
Is your child immunized against human papilloma virus (HPV)? ..... ❑ YES ❑ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions ..... ❑ YES ❑ NO
Problems with physical growth or development ..... ❑ YES ❑ NO

Sinusitis, chronic adenoid/tonsil infections ..... ❑ YES ❑ NO
Sleep apnea/snoring, mouth breathing, or excessive gagging ..... ❑ YES ❑ NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ..... ❑ YES ❑ NO
Irregular heart beat or high blood pressure ..... ❑ YES ❑ NO

Asthma, reactive airway disease, wheezing, or breathing problems ..... ❑ YES ❑ NO
Cystic fibrosis ..... ❑ YES ❑ NO
Frequent colds or coughs, or pneumonia ..... ❑ YES ❑ NO
Frequent exposure to tobacco smoke ..... ❑ YES ❑ NO

Jaundice, hepatitis, or liver problems ..... ❑ YES ❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ..... ❑ YES ❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ..... ❑ YES ❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ..... ❑ YES ❑ NO

Bladder or kidney problems ..... ❑ YES ❑ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis ..... ❑ YES ❑ NO
Rash/hives, eczema or skin problems ..... ❑ YES ❑ NO

Impaired vision, visual processing, hearing, or speech ..... ❑ YES ❑ NO
Developmental disorders, learning problems/delays, or intellectual disability ..... ❑ YES ❑ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ..... ❑ YES ❑ NO
Autism/autism spectrum disorder ..... ❑ YES ❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness ..... ❑ YES ❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ..... ❑ YES ❑ NO

Attention deficit/hyperactivity disorder (ADD/ADHD) ..... ❑ YES ❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment ..... ❑ YES ❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect ..... ❑ YES ❑ NO

Diabetes, hyperglycemia, or hypoglycemia ..... ❑ YES ❑ NO
Precocious puberty or hormonal problems ..... ❑ YES ❑ NO
Thyroid or pituitary problems ..... ❑ YES ❑ NO

Anemia, sickle cell disease/trait, or blood disorder ..... ❑ YES ❑ NO
Hemophilia, bruising easily, or excessive bleeding ..... ❑ YES ❑ NO
Transfusions or receiving blood products ..... ❑ YES ❑ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant ..... ❑ YES ❑ NO

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS ..... ❑ YES ❑ NO

PROVIDE DETAILS HERE: _____
_____
_____

Is there any other significant medical history **pertaining to this child or his/her family** that the dentist should be told? ..... ❑ YES ❑ NO
If YES, describe _____
_____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

your oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

the oral health of your other children? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Not applicable

Is there a family history of cavities? ❑ YES ❑ NO If yes, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	❑ YES	❑ NO	_____
Mouth sores or fever blisters	❑ YES	❑ NO	_____
Bad breath	❑ YES	❑ NO	_____
Bleeding gums	❑ YES	❑ NO	_____
Cavities/decayed teeth	❑ YES	❑ NO	_____
Toothache	❑ YES	❑ NO	_____
Injury to teeth, mouth or jaws	❑ YES	❑ NO	_____
Clinching/grinding his/her teeth	❑ YES	❑ NO	_____
Jaw joint problems (popping, etc.)	❑ YES	❑ NO	_____
Excessive gagging	❑ YES	❑ NO	_____
Sucking habit after one year of age	❑ YES	❑ NO	If yes, which: ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other ❑ For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ❑ YES ❑ NO

How often does your child floss his/her teeth? ❑ Never ❑ Occasionally ❑ Daily Does someone help your child floss? ❑ YES ❑ NO

What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ❑ City/community supply ❑ Private well ❑ Bottled water

Do you use a water filter at home? ❑ YES ❑ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel ❑ Prescription drops/tablets/vitamins

❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrician/other practitioner ❑ Other: _____

Does your child regularly eat 3 meals each day?	❑ YES	❑ NO	
Is your child on a special or restricted diet?	❑ YES	❑ NO	If YES, describe: _____
Is your child a 'picky eater'?	❑ YES	❑ NO	If YES, describe: _____
Does your child have a diet high in sugars or starches?	❑ YES	❑ NO	If YES, describe: _____
Do you have any concerns regarding your child's weight?	❑ YES	❑ NO	If YES, describe: _____

How frequently does your child have the following?

Candy or other sweets	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____
Chewing gum	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Type _____
Snacks between meals	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Usual snack _____
Soft drinks*	❑ Rarely	❑ 1-2 times/day	❑ 3 or more times/day	Product _____

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? ❑ YES ❑ NO If YES, list: _____

Does your child wear a mouthguard during these activities? ❑ YES ❑ NO If YES, type: _____

Has your child been examined or treated by another dentist? ❑ YES ❑ NO

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ❑ YES ❑ NO Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ❑ YES ❑ NO If YES, when? _____

Has your child ever had a difficult dental appointment? ❑ YES ❑ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very poorly

Is there anything else we should know before treating your child? ❑ YES ❑ NO

If yes, describe: _____

_____

_____ _____ _____ _____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing history

MEDICAL / DENTAL HISTORY UPDATE

Is your child being treated by a physician at this time? Reason _____	❑ YES	❑ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ……..……..	❑ YES	❑ NO
List name, dose, frequency & date started: _____		
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? ……..…….	❑ YES	❑ NO
Describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe: _____	❑ YES	❑ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: _____	❑ YES	❑ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	❑ YES	❑ NO
Have there recently been any significant changes/disruptions to your child's family, home, or school routines? …….....	❑ YES	❑ NO
Describe: _____		
What is your primary concern regarding your child's oral health? _____		
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? …….....	❑ YES	❑ NO
Describe: _____		
Has your child's diet changed significantly since his/her last dental visit? Describe: _____	❑ YES	❑ NO
Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____	❑ YES	❑ NO
Is there any other change in the child's medical, dental, or family history that the dentist should be told?	❑ YES	❑ NO
Describe: _____		

_____ _____ _____ _____

Signature of parent/guardian **Relationship to child** **Date** **Signature of staff member reviewing history**

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? ❑ YES ❑ NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breast-fed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

How long was your child bottle-fed? ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Do/did you feed your child infant formula? ❑ YES ❑ NO If YES, what type? (check one): ❑ Ready to use ❑ Powdered ❑ Liquid concentrate

Does/did your child sleep with a bottle? ❑ YES ❑ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ❑ YES ❑ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? ❑ YES ❑ NO

When did you begin brushing his/her teeth? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

When did you begin using toothpaste? ❑ N/A ❑ before age 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____

_____

_____ _____ _____ _____

Signature of parent/guardian | Relationship to child | Date | Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient)

For each YES response, please describe:

Do you have any concerns about your mouth, teeth, or oral health? ❑ NO ❑ YES _____

Have you recently experienced any dental/oral pain? ❑ NO ❑ YES _____

Do you have any concerns with the appearance of your teeth or smile? ❑ NO ❑ YES _____

Do you bleach your teeth? ❑ NO ❑ YES _____

Have there been any recent changes in your dietary habits? ❑ NO ❑ YES _____

Are you taking any dietary or herbal supplements? ❑ NO ❑ YES _____

Do you participate in sports or high speed activities (for example skiing, four-wheeling, motorcycling)? ❑ NO ❑ YES _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

- Oral habits (chewing fingernails, clenching/grinding teeth, etc.) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Electronic cigarette (e-cig) use ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Eating disorder (anorexia, bulimia, etc.) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Oral piercings/jewelry (including grill) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Alcohol or recreational drug use/prescription abuse ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Inhalant use/abuse (such as huffing) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Sexual activity (including oral sex) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Abuse (physical, sexual, verbal, mental) ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER
- Anxiety, depression, or feeling helpless/hopeless ❑ NO ❑ YES ❑ PREFER NOT TO ANSWER

Females: Are you pregnant or possibly pregnant? ❑ NO ❑ YES

Is there anything you would like to discuss confidentially with your dentist? ❑ NO ❑ YES

Would you like to discuss a referral to a family dentist or general dentist because of your age? ❑ NO ❑ YES

_____ _____ _____

Signature of patient | Date | Signature of staff member reviewing history

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify) _____

_____

A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.
REQUEST AND CONSENT FOR DENTAL TREATMENT

Please read this form *carefully*. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

1. I request and authorize the dental treatment by the doctor(s) and staff at Simply Orthodontics & Pediatric Dentistry.

   Patient Name: _____

2. I am the legal guardian of the child named above. **Initials** _____

3. I request and authorize the following dental procedures to be done for my child:

☐Comprehensive dental examination ☐Radiographs (X-Rays), ☐Prophylaxis (dental cleaning), ☐Fluoride application, ☐Restorations (fillings), ☐Stainless steel crowns, ☐Extractions, ☐Nitrous Oxide (Laughing gas) ☐Space maintainers.
☐Pulp treatment (root canal treatment, pulpotomy, pulp cap, pulpectomy)
☐Sealants

4. I further request and authorize the re-taking of dental x-rays if needed and the use of such local anesthetics as may be considered necessary to treat my child's dental need(s).

5. I have had explained to me by the dentists and staff, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

6. It is unusual for any of the following risks or complications to occur. These risks or complications include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

7. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

8. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. **I understand** that treatment for children

includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

9. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold the patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open their mouth.

   Initials _____

10. **I understand** that it is not an uncommon response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have their treatment completed in the operating room under general anesthesia.

11. **I further understand** that should the patient become uncooperative during dental procedures with excessive body movements, or is not able to tolerate the procedure, the treatment would be stopped and alternate treatment plan will be discussed.

12. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.

13. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

14. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

Signature of Person Consenting to Treatment _____ Date _____

Interpreter or Witness _____ Date _____