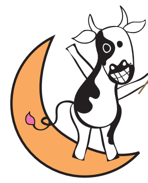
New Patient Information



Smile Bright
Pediatric Dental Care
Dr. Linda Cao

Tell Us About Your Child

Today's Date: ______________________________

Child's Name: ______________________________
Last First Middle

Child's Birthdate: ____/____/________ Child's Age: __________

Nickname: ______________________ ❑ Male ❑ Female

School: ______________________________ Grade: ______

Home #: ______________________________

SS #: ______________________________

Address: ______________________________
#Apt. / Condo

____
City State Zip Code

Siblings:

Name: ______________________________ Age: __________

Name: ______________________________ Age: __________

Who is with the child today?

Name: ______________________________

Relation: ______________________________

Do you have legal custody of this child?

❑ Yes ❑ No

Who may we thank for referring you? ______________________

____

Other family members seen by us? ______________________

____

Previous/Present Dentist: ______________________________

Address: ______________________________

Phone #: ________________ Last Visit: ________________

Parent's Marital Status: ❑ Single ❑ Married ❑ Divorced

Mother's Information

Name: ______________________________

WK #: ________________ Ext. _____ HM #: ______________

Employer: ______________________________

DL #: ______________________________

SS #: ______________________________

❑ Check if deceased

Father's Information

Name: ______________________________

WK #: ________________ Ext. _____ HM #: ______________

Employer: ______________________________

DL #: ______________________________

SS #: ______________________________

❑ Check if deceased

Responsible Party Info:

Name: ______________________________

Billing Address: ______________________________

____
City State Zip Code

WK #: ________________ Ext. _____ HM #: ______________

Cell #: ______________________________

Email: ______________________________

Employer: ______________________________

DL #: ______________________________

SS #: ______________________________

Who is responsible for making appts?

Name: ______________________________

WK #: ________________ Ext. _____ HM #: ______________

Primary Dental Insurance

Ins. Name: ______________________________

Ins. Address: ______________________________

____
City State Zip Code

Insurance Co Phone #: ______________________

Group/Policy #: ______________________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured Date of Birth: ______________________

Insured Employer: ______________________

SS #: ______________________

Orthodontic Coverage: ❑ Yes ❑ No

Secondary Dental Insurance

Ins.Name: ______________________________

Ins. Address: ______________________________

____
City State Zip Code

Insurance Co Phone #: ______________________

Group/Policy #: ______________________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured Date of Birth: ______________________

Insured Employer: ______________________

SS #: ______________________

Orthodontic Coverage: ❑ Yes ❑ No

Dental History

Why did you bring the child to see the dentist today?

☐ Refered ☐ Trauma ☐ Emergency ☐ Consultation

____

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Does the child floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician:______________________________________

Phone #: (   )_________________ Date of Last Visit: _______________

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐Good ☐Fair ☐Poor

Please list any drugs that the child is currently taking: _______________

____

____

Please list all drugs that the child is allergic to:

____

____

Y N Allergic to Latex

Y N Allergic to Nickel

Y N Allergic to Metals

Y N Allergic to Plastic

Primary Language Spoken: ____ English ____ Spanish ____ Vietnamese ____ Chinese ____ Arabic ____ Other (__________________)

Medical History

Has the child experienced any of the following medical problems or been diagnosed with any of the following:

Y N Abnormal Bleeding/ Hemophilia/Von Williebrand

Y N ADD/ADHD

Y N AIDS/HIV +

Y N Anemia

Y N Any Hospital Stays/Operations?

Y N Artificial Bones/Joints/Valves

Y N Asthma – Stable or Unstable?

Y N Autism Spectrum/SPD/Asperger

Y N Cancer – Specify

Y N Chicken Pox

Y N Congenital Heart Defect

Y N Convulsions

Y N Diabetes – Type I/Type II

Y N Epilepsy

Y N Handicaps/Disabilities

Y N Hearing impairment

Y N Heart Murmur: Any other heart disorders, concerns or issues

Y N Bronchitis/RAD

Y N Hepatitis – A, B or C

Y N High Blood Pressure

Y N Hives

Y N Immune Suppressive Therapy

Y N Kawasaki Disease

Y N Kidney Problems

Y N Liver Problems

Y N Low Blood Pressure

Y N Lupus

Y N Measles

Y N Mitral Valve Prolapse

Y N Mononucleosis

Y N Prosthetics

Y N Rheumatic Fever

Y N Rheumatoid Arthritis

Y N Scarlet Fever

Y N Skin Rash

Y N Tuberculosis (TB)

Y N Sensory Integration Disorder/Dysfunction

Are the child's immunizations current? ☐ Yes ☐No

Is there anything you would like to discuss with the Doctor in Private? ☐ Yes ☐No

Please discuss any serious medical problems the child experiences/ed:

____

____

Does/did the child experience any of the following?

Y N Bottle for Feedings

Y N Breast Fed

Y N Chewing on Objects

Y N Clenching/Grinding Teeth

Y N Dental Phobia

Y N Lip Sucking/Biting

Y N Pacifier

Y N Mouth Breather

Y N Nail Biting

Y N Speech Problems

Y N Thumb/finger Sucking

Y N Tongue/Cheek Sucking

Y N Tongue Thrust

Y N Full Term Birth

Y N Premature Birth ____weeks

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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.

______________________________ ______________

Signature of Parent or Guardian Date

Insurance Release

I certify that my child is covered by ______________________________ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________ ______________

Signature of Parent or Guardian Date

Consent for Basic Routine Dental Care

I give consent to dentist to perform routine examinations, cleanings, x-rays, and fluoride treatment.

______________________________ ______________________________ ______________

Print Name Signature Relationship to Child

OFFICE USE ONLY

I verbally reviewed the medical/dental information about the the parent/guardian & patient named herein.

Initials: ______________________Date: ____________________________

Doctor's comments: _________________________ ASA I, II, III or IV________

WHICH OFFICE ARE YOU SEEN

☐ **Metairie** | 3330 Kingman Street, Suite 1 | Metairie, LA 70006

☐ **Harvey** | 2800 Manhattan Blvd., Suite D | Harvey, LA 70058