Specializing in dentistry for infants, children & adolescents.

Hello and welcome to Where Smiles Grow
Please help us by completing the following information regarding your child:

CHILD'S NAME ____________ NICKNAME ____________ HOME PHONE ____________
HOME ADDRESS ____________
CITY ____________ SOC. SEC. NO. ____________
STATE ____________ ZIP ____________ BIRTH DATE ____________ SEX: M/F
Your Child's Favorite:
Person ____________ Fictional Character ____________ Toy ____________
Hobby ____________ Sport ____________
SCHOOL ____________ Grade ____________
Other children in family (names and ages): ____________
Tell us about your child's home environment: ____________

Anything else you feel would help us to get to know your child better?: ____________

How did you hear about our practice?
☐ Doctor/Dentist Name: ____________ Address: ____________
☐ Family/Friend Name: ____________ Address: ____________
☐ Social Media (Facebook) ☐ Internet Search ☐ Television ☐ Community Event: ____________ ☐ Other: ____________
In case of emergency - who should be notified? (other than parent) ____________ Phone #: ____________

PARENT/GUARDIAN ____________ Home Phone ____________ Cell# ____________
Home Address (IF DIFFERENT) ____________ Work Phone ____________ Ext. ____________
City ____________ Soc. Sec. No. ____________
State ____________ Zip ____________ Birth Date ____________
Email Address ____________ Marital Status ____________
Employer's Name ____________ Job Title ____________
Employer's Address ____________
Please complete the following if you have dental insurance coverage in this parent/guardian's name:
Dental Insurance Co. Name ____________ Dental Group No. ____________
Ins. Co. Mailing Address ____________ Member/Policy No. ____________

PARENT/GUARDIAN ____________ Home Phone ____________ Cell# ____________
Home Address (IF DIFFERENT) ____________ Work Phone ____________ Ext. ____________
City ____________ Soc. Sec. No. ____________
State ____________ Zip ____________ Birth Date ____________
Email Address ____________ Marital Status ____________
Employer's Name ____________ Job Title ____________
Employer's Address ____________
Please complete the following if you have dental insurance coverage in this parent/guardian's name:
Dental Insurance Co. Name ____________ Dental Group No. ____________
Ins. Co. Mailing Address ____________

If divorced, who has legal custody (please circle one:) Mother Father Joint Other

Please turn over to complete comprehensive medical/dental history.
Thank you.

9 Century Hill Drive • Latham, NY 12110
ph: 518.785.3911 • f: 518.785.4910

250 Delaware Avenue • Delmar, NY 12054
www.wheresmilesgrow.com

CHILD'S COMPREHENSIVE MEDICAL HISTORY

Child's physician ______________ Address ______________ Phone ______________

Date of last physical ______________ Results ______________

Child's current weight ______________ Height ______________

Is your child:

Under medical care now? No _____ Yes _____ Why ______________

Receiving any medications or drugs? No _____ Yes _____ Why ______________

Ever been hospitalized? No _____ Yes _____ When & Why ______________

Ever had surgery? No _____ Yes _____ When & Why ______________

Tonsils & Adenoids removed? No _____ Yes _____ When ______________

Any excessive bleeding when cut? No _____ Yes _____ Please Explain ______________

Immunization record up to date? Yes_____ No _____ Please Explain ______________

Good physical coordination? Yes_____ No _____ Please Explain ______________

Any unusual prenatal & pregnancy history? No _____ Yes _____ Please Explain ______________

Any illnesses/drugs/medications during pregnancy No _____ Yes _____ Please Explain ______________

Please describe child's infant health status:

Any allergies to (circle) Penicillin Foods Pollen Animals Dust Comments ______________

Tendency to (circle) Colds Sore Throats Ear Infections Comments ______________

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? *PLEASE CIRCLE NUMBER:*

1 ADENOIDECTOMY
2 AIDS/HIV+
3 ALLERGY
4 ANTIBIOTIC ALLERGY
5 ANEMIA
6 ARTHRITIS
7 ASTHMA
8 AUTISM SPECTRUM
9 BLADDER PROBLEMS
10 BLEEDING PROBLEMS
11 BONE DISORDERS
12 BRONCHITIS
13 CEREBRAL PALSY
14 CHEMOTHERAPY
15 CHICKEN POX
16 SINUSITIS
17 COLD SORES
18 DIABETES
19 DOWN'S SYNDROME
20 EAR INFECTION
21 EMOTIONAL PROBLEMS
22 ENDOCRINE PROBLEMS
23 EPILEPSY
24 ERYTHROMYCIN ALLERGY
25 FAINTING
26 HEARING IMPAIRED
28 HEART DISEASE
27 HEMOPHILIA
29 HEPATITIS
30 UNUSUAL HEREDITARY HABITS
31 HERPES
32 HIGH FEVER (OFTEN)
33 HOME ENVIRONMENT (UNUSUAL)
34 HOSPITALIZATIONS
35 HYPERACTIVITY
36 IMMUNIZATIONS
37 KIDNEY DISEASE
38 LIVER DISEASE
39 LUNG DISEASE
40 MALIGNANT DISEASE
41 MASTOIDITIS
42 MEASLES
43 ON MEDICATION
45 MONONUCLEOSIS
44 MUMPS
46 PENICILLIN ALLERGY
47 PNEUMONIA
48 UNUSUAL POST NATAL HX
49 UNUSUAL PREGNANCY HX
50 PREMEDICATION
51 UNUSUAL PRENATAL HX
52 PSORIASIS
53 RADIATION THERAPY
54 RHEUMATIC FEVER
55 SEIZURE DISORDER
56 SPEECH PROBLEMS
57 STREP THROAT (OFTEN)
58 SURGERY (SIGNIF)
59 THYROID PROBLEMS
60 TONSILLECTOMY
61 TUBERCULOSIS
62 RESPIRATORY INFECTION (OFTEN)
63 VISION IMPAIRED
64 WHEELCHAIR
65 TRANSFUSIONS
66
67

I give my permission for release of my child's medical records to J.T. Decker, DDS, N.A. Cavotta, DDS, J.L. Charlesworth, DMD, K. Carroll, DMD and Daniel C. Caban, DMD as may be judged necessary by the doctors.
The medical/dental information provided on this form has been given by:

Name ______________

Date ______________ Relationship to Child ______________ and has been fully

discussed with the above names person by: ______________ Date ______________

CHILD'S COMPREHENSIVE DENTAL HISTORY

Do you suspect any dental problems: No _____ Yes _____ Type: ______________

Chief concern regarding child's oral health: ______________

Date of child's last visit to dentist: ______________ Name of dentist: ______________

Any unhappy dental experiences? No _____ Yes _____ What Happened? ______________

Your attitude toward dentistry: ______________

Child's anticipated behavior at first dental visit: (Circle One) • Happy • So -So • Apprehensive, Cooperation Doubtful • Terrified, Uncooperative

Does your child: (Circle) • Grind Teeth • Suck: Finger / Thumb / Pacifier • Resist Brushing

Or have the following: (Circle) • White Spots on Teeth • Missing Teeth • Loose Teeth • Decay • Nursing Bottle Mouth • Gum Problems • Poor Brushing • Back White Fillings • Fillings of Any Kind • Nerve Treatments • Multiple Unfilled Cavities • Sealants • Space Maintainers • Speech Problems • Stainless Steel Crowns • White Front Crowns • Extra Teeth • Unusually Shaped Teeth • Abscesses

AUTHORIZATION: I grant authority (upon verbal consent) to the dentist/hygienist and staff to perform a thorough oral examination, prophylaxis, topical fluoride application, and take X-rays judged to be necessary to provide a complete diagnosis of my child's dental condition. Any treatment recommendations will be discussed separately.

Signature ______________ Date ______________ Relationship to Child ______________

THANK YOU FOR HELPING US TO BECOME BETTER ACQUAINTED WITH YOUR CHILD