pediatric smiles of bloomington
Come Smile with Us

1112 Trinity Lane
Bloomington, IL 61704
309.663.7339
PediatricSmilesOfBloomington.com

Thomas D. Hall, D.M.D.
Sara Rauen Dardis, D.D.S., M.S.

Patient Info

Today's Date: _____

Child's Name: _____ (Last / First / MI) Child's Birthdate: ____/____/____ Child's Age: ____

Nickname: _____ ☐ Male ☐ Female School: _____ Grade: ____

Contact number to confirm appointments: _____ Whom may we thank for referring you? _____

What is the primary reason for today's visit? _____

Medical History

Child's Physician: _____ Phone: (_____) _____ Date of last visit: _____

Address: _____ (Street / City / State / Zip)

Is your child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor Are immunizations current? ☐ Yes ☐ No

Please list all medications and dosage that your child is currently taking: _____

Please list all drugs and/or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Has your child had/experienced any of the following: (please circle)

Y ☐ N ☐ Abnormal Bleeding	Y ☐ N ☐ Cancer / Tumors	Y ☐ N ☐ Heart Murmur	Y ☐ N ☐ Pregnancy
Y ☐ N ☐ ADD / ADHD	Y ☐ N ☐ Chicken Pox	Y ☐ N ☐ Hemophilia	Y ☐ N ☐ Recurrent Headaches
Y ☐ N ☐ AIDS / HIV+	Y ☐ N ☐ Congenital Birth Defect	Y ☐ N ☑ Hepatitis	Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Allergies	Y ☐ N ☐ Congenital Heart Defect	Y ☐ N ☐ High Blood Pressure	Y ☐ N ☐ Seizures
Y ☐ N ☐ Anemia	Y ☐ N ☐ Diabetes	Y ☐ N ☐ Hives	Y ☐ N ☐ Sickle Cell Anemia
Y ☐ N ☐ Any Hospital Stays	Y ☐ N ☐ Endocrine System Disorders	Y ☐ N ☐ Kidney Problems	Y ☐ N ☐ Vision Problems
Y ☐ N ☐ Any Operations	Y ☐ N ☐ Epilepsy	Y ☐ N ☐ Liver / GI System Problems	Y ☐ N ☐ Skin Rash
Y ☐ N ☐ Arthritis	Y ☐ N ☐ Frequent Infections	Y ☐ N ☐ Low Blood Pressure	Y ☐ N ☐ Tonsilitis
Y ☐ N ☐ Asthma	Y ☐ N ☐ Behavior / Learning Disabilities	Y ☐ N ☐ Measles	Y ☐ N ☐ Tuberculosis (TB)
Y ☐ N ☐ Autism/Aspergers	Y ☐ N ☐ Mentally / Physically Disabled	Y ☐ N ☐ Mitral Valve Prolapse	
Y ☐ N ☐ Breathing / Lung Problems	Y ☐ N ☐ Hearing Impaired	Y ☐ N ☐ Mononucleosis	

Please discuss any serious medical problems your child experiences, now or in the past: _____

Dental History

Is your child currently in pain? ☐ Yes ☐ No Is this your child's first dental visit? ☐ Yes ☐ No

Has your child experienced problems with previous dental work? ☐ Yes ☐ No If so, explain: _____

Previous Dentist: _____ Date of last visit: _____ Date of last X-Ray: _____

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc.? ..... ☐ Yes ☐ No

Does your child take fluoride vitamins or drink fluoridated water? ..... ☐ Yes ☐ No

Has your child been seen by an orthodontist? ..... ☐ Yes ☐ No Who? _____

Does your child brush his/her teeth daily? ..... ☐ Yes ☐ No How often? _____ Do you assist? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ..... ☐ Yes ☐ No How often? _____ Do you assist? ☐ Yes ☐ No

Does/did your child have any of the following habits? (please circle)

Y ☐ N ☐ Lip sucking and nail biting	Y ☐ N ☐ Chewing on objects	Y ☐ N ☐ Jaw pain	Y ☐ N ☐ Clenching/grinding teeth
Y ☐ N ☐ Thumb/finger sucking	Y ☐ N ☐ Nursing bottle habits	Y ☐ N ☐ Tongue/cheek biting	Y ☐ N ☐ Used pacifier
Y ☐ N ☐ Tongue thrust	Y ☐ N ☐ Mouth breathing	Y ☐ N ☐ Speech problems	Y ☐ N ☐ Breastfed

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Parent's Information

Family's E-Mail: _____

Mother or Guardian: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Social Security #: _____ Birthdate: ____/____/____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Father or Guardian: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Name: _____ Social Security #: _____ Birthdate: ____/____/____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Name of parent who resides with the child: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____

Is your child covered by a dental insurance plan? ☐ Yes ☐ No

Insurance Information

Primary Dental Insurance

Insured's Name: _____ Relationship to Patient: _____

Insured's Address (if different from above): _____
Street / PO Box City State Zip

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Insured's Employer Address: _____ Phone: (_____) _____

Insurance Co. Name: _____ Phone: (_____) _____ Group # _____ ID# _____

Insurance Co. Address: _____

Secondary Dental Insurance

Insured's Name: _____ Relationship to Patient: _____

Insured's Address (if different from above): _____
Street / PO Box City State Zip

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Insured's Employer Address: _____ Phone: (_____) _____

Insurance Co. Name: _____ Phone: (_____) _____ Group # _____ ID# _____

Insurance Co. Address: _____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

Signature: _____ Relationship: _____ Date: _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and or their health practitioners.

If I request, I will be provided a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Relationship: _____ Date: _____