Dr. John Gennantonio • Dr. Katie Stewart
Dr. Sarah Husted
Diplomat, American Board of Pediatric Dentistry

Sea of Smiles
Pediatric Dentistry

Patient Name	❑ Male ❑ Female	Date of Birth

Address _____ City _____

State _____ Zip _____ Home Phone _____

Email Address _____

Child's School _____ Sibling Names _____

Hobbies _____

Mother's Name _____ Mother's Cell Phone _____

Mother's S.S. No. _____ Mother's D.O.B. _____ Employed By _____

Father's Name _____ Father's Cell Phone _____

Father's S.S. No. _____ Father's D.O.B. _____ Employed By _____

How did you hear about our office? _____

PRIMARY DENTAL INSURANCE ❑ Same ❑ N/A

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

SECONDARY DENTAL INSURANCE ❑ Same ❑ N/A

Name of Insured _____ Relationship to Patient _____

Insured's Date of Birth _____ Social Security Number _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Member ID _____ Group # _____

Claims Address _____ City _____ State _____ Zip _____

Insurance Company Phone Number _____

In case of emergency, please list the name, phone number and relationship to the patient not living at home:

_____

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any/and all necessary dental services be rendered. Authorization is hereby granted for Sea of Smiles to provide dental care for this child. Furthermore, I acknowledge receipt of the office policy as to charges and payments and agree to comply. I will be financially responsible for the charges incurred for the dental treatment of this child.

Signature of Parent/Guardian _____ **Relationship to Patient** _____

Print Name _____ **Date** _____

OVER⇨

Dr. John Gennantonio • Dr. Katie Stewart
Dr. Sarah Husted
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Patient Name	❑ Male ❑ Female	Date of Birth

Date of last physical exam: _____ Weight: _____
Name/address/phone of primary physician: _____
_____
Name/address/phone number of medical specialist: _____
_____

MEDICAL/DENTAL HISTORY UPDATE

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

Is your child being treated by a physician at this time? …… ❑ YES ❑ NO
Reason _____

Is your child taking any medications (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? …… ❑ YES ❑ NO
Describe: _____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? …… ❑ YES ❑ NO
List: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? …… ❑ YES ❑ NO
List _____

Is your child allergic to tree nuts, soy, Birch trees, etc.? …… ❑ YES ❑ NO
List _____

Have there recently been any significant changes/disruptions to your child's family, home or school routines? ..…….. ❑ YES ❑ NO
Describe: _____

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? ❑ YES ❑ NO
Describe: _____

Has your child been treated by another dentist/dental professional since last visiting our office? …… ❑ YES ❑ NO
Reason: _____

Is there any other change in the child's medical, dental, or family history that the dentist should be told? ……..……... ❑ YES ❑ NO
Describe: _____

The statements on both sides of this form are to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examination, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

Signature of Parent/Guardian _____ **Relationship to Patient** _____

Print Name _____ **Date** _____