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

POS Reorder # 1206248