Growing Smiles Pediatric Dentistry

4207 N Prospect Road
Peoria Heights, IL 61616
(309)685-4444

Thank you for choosing our practice for your child's dental needs! Please complete this form, and if you have any questions, do not hesitate to ask for assistance. We will be happy to help!

Today's Date:_____

PATIENT INFORMATION

Child's Name:_____ Nickname:_____ DOB:_____
Address:_____City:_____ State:____Zip:_____
Name of school patient attends:_____ Sex: ☐ Male ☐ Female
Person Financially Responsible:_____Home Phone:_____
For Confirmation Calls and Texts, please list the best cell phone number and email address:
Cell Phone: _____ E-mail:_____
Whom may we thank for referring you? _____
Does your child have siblings? _____ If so, names & ages:_____

PARENT INFORMATION

Father's/Guardian's Name:_____
Address (if different from above):_____
_____
Home Number:_____
Cell Number:_____
Employer:_____
Occupation:_____
Work Number:_____
SS #: _____Birthdate:_____

Mother's/Guardian's Name:_____
Address (if different from above):_____
_____
Home Number:_____
Cell Number:_____
Employer:_____
Occupation:_____
Work Number:_____
SS #:_____Birthdate:_____

INSURANCE INFORMATION

Name of Policy Holder:_____ Birthdate:_____
Policy Holder Social Security Number:_____ Plan Name:_____
Address:_____ Phone Number:_____
Group Number:_____ Policy Number:_____

DENTAL HISTORY

Family Dentist:_____ Has your child been to a dentist before: ☐ YES ☐ NO
Past experiences at the dentist:_____
Date of Last Exam:_____ Date of Last X-Rays:_____
Any mouth habits (pacifier, thumbsucking, sippy cup, grinds, etc):_____
Is your child getting fluoride in their water?_____
How often does your child brush?_____ Floss?_____
Has your child had any dental problems/pain:_____
Any injuries to the mouth, teeth, or head:_____
What is the reason for today's visit?_____

EMERGENCY INFORMATION

Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

In my absence, I give permission to:_____
to accompany my child and consent for any needed treatment.

MEDICAL HISTORY

Child's Physician:_____ City, State: _____ Phone: _____

Is your child taking any medication? ☐ YES ☐ NO
If yes, please explain:_____
Are your child's immunizations up to date? ☐ YES ☐ NO
Has your child had any major illnesses? ☐ YES ☐ NO
If yes, please explain:_____
Has your child had any operations/hospital stays? ☐ YES ☐ NO
If yes, please explain:_____
Is your child allergic to any medication? ☐ YES ☐ NO
If yes, please explain:_____
Is your child allergic to any foods? ☐ YES ☐ NO
If yes, please explain:_____

Has your child had any of the following (please check any that apply):

☐ ADD/ADHD	☐ Hearing Impairment	☐ Radiation/Chemotherapy
☐ Autism	☐ Heart Problems	☐ Seizures
☐ Asthma	☐ Hepatitis/Liver Problems	☐ Special Needs
☐ Bleeding Problems	☐ HIV/AIDS	☐ Tobacco Use
☐ Cancer	☐ High Fevers	☐ Tonsil/Adenoid Problems
☐ Celiac Disease	☐ Kidney Problems	☐ Vision Problems
☐ Cleft Lip/Palate	☐ Nervous or Emotional Problems	☐ Women: Birth Control
☐ Diabetes	☐ Neck, Back, Jaw Pain	☐ Women: Pregnancy

Are there any medical conditions that you feel we should be aware of? ☐ Yes ☐ No
If yes, please explain:_____

AURTHORIZATION

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform Growing Smiles Pediatric Dentistry of any changes in my child's medical status.

I authorize the dental staff to provide the necessary dental services needed by my child and agree to pay all fees and charges.

It is agreed that all proceeds of insurance are assigned to this office when applicable. Growing Smiles Pediatric Dentistry may use my health information to the above mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the remainder of the balance within 90 days of the first statement.

In the event that I fail to pay all charges due within 90 days of our first statement, I may be responsible for the balance and any charges associated with collection attempts. I also agree to release all information in order for a collection agency to reach me. This authorization will remain in effect until revoked by me in writing.

Signature of Parent or Guardian: _____ Date:_____

Printed Name of Parent or Guardian: _____

Relationship to Patient: _____