Elite Smile
(908) 355-0300
324 Morris Ave.
Elizabeth, NJ 07208
www.elitesmile.com

Welcome

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.

Chart# _____

About Your Child

Today's date: ____/_____/_____

Name _____
Last First MI

SS# : _____-____-_____ Birth Date:____/____/____ o Male o Female

Childs Home # :(____) _____-_____ Other Phone #:(_____) _____-_____

Email_____

Childs Home Address: _____
apt#

_____
City State zip code

Informacion General

Who is accompanying the child today?

Name_____
Last First MI

Relation_____

Do you have legal custody of this child? o Yes o No

Home Phone #:(____) _____-_____ Cellular Phone # :(____) _____-_____

Email_____

Address: _____
apt#

_____
City State zip code

Referred by:_____

Parent's Information

Who is responsible for account? _____ **Parent's Marital Status:** oSingle o Married o Widowed oDivorced

oFather oStep Father o Guardian **o Mother oStep Mother o Guardian**

Name_____ **Name**_____

Date of Birth: ____/____/_____ **SS#**_____ **Date of Birth:** _____/_____/_____ **SS#**_____

Address: (If different than child's) **Address:** (If different than child's)

_____
apt#

_____
City State zip code

_____
apt#

_____
City State zip code

Cell # :(____) _____-_____ Email:_____ **Cell # :(____) _____-_____ Email:**_____

Employer: _____ **Employer:** _____

Employer's Address: _____ **Employer's Address:** _____

_____
City State zip code City

_____
State zip code

Work #:(____) _____-_____ **Work #:(____) _____-_____**

Insurance Name_____ **Insurance Name**_____

Insurance Tel #_____ **Group #**_____ **Insurance Tel #**_____ **Group #**_____

Medical History

Is the child currently under the care of a physician? o Yes o No

Please explain: _____

Name of physician _____ Tel #:_____ Date of last visit:_____

Please describe the current health of the child: o Good o Regular o Poor

Are the child immunizations current? o Yes o No Anything you would like to discuss with the doctor in private? o Yes o No

Please discuss any serious medical problems the child has experiences: _____

Has the child experience any of the following medical problems?

o Yes o No Abnormal Bleeding / Hemophilia	o Yes o No ADD/ADHD	o Yes o No Exposed to HIV, but negative
o Yes o No Anemia	o Yes o No Diabetes	o Yes o No Handicap / Disabilities
o Yes o No Any Hospital stays / Operations	o Yes o No Epilepsy	o Yes o No Hearing impair
o Yes o No Artificial Bones / Joints / Valves	o Yes o No Heart Murmur	o Yes o No High / Low blood pressure
o Yes o No Asthma	o Yes o No Hepatitis	o Yes o No Kidney Problems
o Yes o No Cancer	o Yes o No Hives	o Yes o No Problem Rheumatic Fever
o Yes o No Chicken Pox	o Yes o No Lupus	o Yes o No Tuberculosis
o Yes o No Congenital Heart Defect	o Yes o No Measles	o Yes o No Mononucleosis
o Yes o No Convulsions	o Yes o No Mononucleosis	o Yes o No Prosthetics

Has the child suffer any other condition not listed above? : o Yes o No

Please explain:_____

Is the child allergic to any of the following?

Aspirin: o Yes o No Codeine: o Yes o No Erythromycin: o Yes o No Tetracycline: o Yes o No

Dental Anesthetic: o Yes o No Latex: o Yes o No

Aside from items listed, please list all drugs/things that the child is allergic to:_____

Office use only: _____

Dental History

Why did you bring the child to the dentist today? _____

Has the child taken any diet pill such as Phen-Fen (Redux o Pondimin.) o Yes o No

Is the child currently in pain? o Yes o No Has the child ever had a serious problem associated with previous dental work? o Yes o No

Does the child require antibiotics before dental treatment? o Yes o No Is the child's water fluoridated? o Yes o No

Is the child taking fluoridated supplements? o Yes o No

Has the child ever had any pain/tenderness in his/her jaw joint? (TMJ, TMD) o Yes o No

Does the child brush his/her teeth daily? o Yes o No Does the child floss his/her teeth daily o Yes o No

Date of last dental visit: _____/_____/_____

Is the child's dental health: o Good o Fair o Poor Do the child's gums bleed? o Yes o No Does the child like his/her smile? o Yes o No

Does/did the child experience any of the following?

o Yes o No Breast fed	o Yes o No Nursing Bottle Habits
o Yes o No Chewing on objects	o Yes o No Speech Problems
o Yes o No Clenching or grinding teeth	o Yes o No Thumb/Finger sucking
o Yes o No Lip sucking/Biting	o Yes o No Tongue/Cheek Biting
o Yes o No Mouth Breather	o Yes o No Tongue Thrust
o Yes o No Nail Biting	o Yes o No Used Pacifier

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Parent/Guardian signature_____ Date _____/_____/_____