



WELCOME to SMILEY KIDZ DENTAL  
Specializing in Children and Adolescents  
Oana Romasan DDS

Today's Date \_\_\_\_\_  
Child's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Telephone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Parent's Information**

Person responsible for account: \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
**MOTHER'S FULL NAME** \_\_\_\_\_ M-S-D-W

Address (if different then patient's) \_\_\_\_\_  
Home Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

e-mail address \_\_\_\_\_

DO You prefer Email or text reminder of appointments and do you prefer land line or cell to be used for any communications

**FATHER'S FULL NAME** \_\_\_\_\_ M\_S\_D\_W

Address (if different then patient's) \_\_\_\_\_  
Home Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License# \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Business Phone \_\_\_\_\_ Fax/Cell or Pager \_\_\_\_\_

e-mail \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT** \_\_\_\_\_

**Dental Insurance Information**

Name of insured \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Employer Name & Address \_\_\_\_\_

Insurance Plan Name \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_

**General Information**

Is this your child's FIRST dental visit? \_\_\_\_\_

Is child adopted? \_\_\_\_\_

Was \_\_\_\_\_ child's \_\_\_\_\_ past \_\_\_\_\_ dental \_\_\_\_\_ experience \_\_\_\_\_ positive? \_\_\_\_\_ If \_\_\_\_\_ not \_\_\_\_\_ please  
explain \_\_\_\_\_

Date of last Dental exam. \_\_\_\_\_ Date of last X-rays \_\_\_\_\_

Name of former dentist \_\_\_\_\_

Was your child nursed or slept with a bottle? \_\_\_Y\_\_\_ N. How long? \_\_\_\_\_  
Has your child had any trauma to face or teeth?

Does your Child Have a toothache now? \_\_\_\_\_

Who may we THANK for referring you to our practice \_\_\_\_\_

Does your child have any of the following habits?

Thumb sucking \_\_\_\_\_ pacifier \_\_\_\_\_ nail biting \_\_\_\_\_ grinding \_\_\_\_\_

Are there any questions or topics you would like Dr. Romasan to Address at This time? \_\_\_\_\_

### Child's Medical History

Name & phone of PEDIATRICIAN \_\_\_\_\_

Date of last medical Exam. \_\_\_\_\_

Is your child taking any medicine or vitamins at this time? Please list \_\_\_\_\_

Has your child ever been hospitalized? Y N If yes, what for and how long? \_\_\_\_\_

Please list any Behavioral or Developmental problems \_\_\_\_\_

Is Child in good health? \_\_\_\_\_

Is Child under care of physician? \_\_\_\_\_ What for? \_\_\_\_\_

**Has the child ever had any of the following? Please circle those that apply:**

Abnormal Heart condition/murmur

Asthma

Allergy to Penicillin

Latex Allergy

Allergy Peanut

Allergies \_\_\_\_\_

Bleeding Disorder

Hepatitis/Liver Disease

Diabetes

Eating Disorders

Stomach Problems

Epilepsy/Seizures

Tumors/Cancer Treatment

Kidney Disease

Exposure to AIDS/HIV

Exposure to TB

Glandular/Hormone Disease

Mental/Nervous Disorder

Please give any other information the doctor should be aware of \_\_\_\_\_

### Consent for Treatment

As the parent/guardian of \_\_\_\_\_ I hereby give my consent for Dr. Romasan to render dental services, anesthesia, and accepted behavior management techniques to and for the benefit of the patient that may be necessary to correct any oral deficiency, abnormality, infection or disease. **NO TREATMENT, ANESTHESIA, OR X-RAYS WILL BE PERFORMED WITHOUT YOUR PRIOR KNOWLEDGE OR CONSENT**

The parent/guardian acknowledges that he/she is responsible for all charges incurred in the rendering of dental services, regardless of what type of insurance he/she carries. This office will make every effort to assist you in filling and processing the claims.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ Relationship to patient \_\_\_\_\_