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_____