**PATIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: |  | Last Name: |  | Nickname: |  | DOB: | Select date | Gender: | M F |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Street Address: |  | City: |  | State: |  | Zip: |  |

|  |  |
| --- | --- |
| Primary number for appointment confirmations: |  |

|  |
| --- |
| **Who is accompanying the child today or is expected to on the date of their appointment?** |
| First Name: |  | Last Name: |  | Relation: |  Biological  Adopted  Foster  Nanny |  Other: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Is your child here only for a tongue tie assessment and treatment? |  Yes  No | What is your primary goal of treatment? |  |

**PARENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Who does the patient live with? (check all that apply):** |  Guardian 1  Guardian 2 |  Other: |  |

**GUARDIAN (I)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Last Name: |  | Gender: |  M  F |

|  |  |  |  |
| --- | --- | --- | --- |
| DOB: | Sep 11, 2020 | SS#: |  |

|  |  |
| --- | --- |
| Marital Status: |  Single  Married  Domestic Partnership  Separated  Divorced  Widowed |

|  |  |  |  |
| --- | --- | --- | --- |
| Home: |  | Cell: |  |

|  |  |
| --- | --- |
| Email: |  |

|  |  |
| --- | --- |
|  Yes No  | Address is same as patient’s listed above. |

|  |  |
| --- | --- |
| Street Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: |  | State: |  | Zip: |  |

|  |  |
| --- | --- |
| Employer: |  |
| Work phone: |  |

**GUARDIAN (II)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Last Name: |  | Gender: |  M  F |

|  |  |  |  |
| --- | --- | --- | --- |
| DOB: | Select date | SS#: |  |

|  |  |
| --- | --- |
| Marital Status: |  Single  Married  Domestic Partnership  Separated  Divorced  Widowed |

|  |  |  |  |
| --- | --- | --- | --- |
| Home: |  | Cell: |  |

|  |  |
| --- | --- |
| Email: |  |

|  |  |
| --- | --- |
|  Yes No  | Address is same as patient’s listed above. |

|  |  |
| --- | --- |
| Street Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: |  | State: |  | Zip: |  |

|  |  |
| --- | --- |
| Employer: |  |
| Work phone: |  |

**DENTAL INSURANCE INFORMATION**

|  |  |
| --- | --- |
|  Yes No  | **Do you have dental insurance coverage?** |

**PRIMARY COVERAGE (Not necessary to complete for BabyLase Services)**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name of Insured: |  | Last Name of Insured: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| DOB: | Select date | SS#: |  |

|  |  |
| --- | --- |
| Employer: |  |
| Employer Phone: |  |

|  |  |
| --- | --- |
| Insurance Co.: |  |
| Street Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: |  | State: |  | Zip: |  |

|  |  |
| --- | --- |
| Phone: |  |

|  |  |
| --- | --- |
| Group/Policy #: |  |
| I.D. #: |  |

**SECONDARY COVERAGE (not necessary for BabyLase Services)**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name of Insured: |  | Last Name of Insured: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| DOB: | Select date | SS#: |  |

|  |  |
| --- | --- |
| Employer: |  |
| Employer Phone: |  |

|  |  |
| --- | --- |
| Insurance Co.: |  |
| Street Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| City: |  | State: |  | Zip: |  |

|  |  |
| --- | --- |
| Phone: |  |

|  |  |
| --- | --- |
| Group/Policy #: |  |
| I.D. #: |  |

**REFERRAL INFORMATION**

|  |
| --- |
| **Please share with us how you heard about our office…** |
|  | Chiropractor |  |  | Speech pathologist |   |
|  | Friend: |  |  | Lactation consultant |   |
|  | Pediatrician/Physician: |  |  | Orofacial myologist |   |
|  | Dentist/Dental Office: |  |  | Athletic trainer |   |
|  | Insurance: |  |  |  |  |
|  | School/Daycare: |  |  |  |  |
|  | Facebook |  |  | Other: |  |

**ORAL HISTORY**

**DENTAL CONCERNS**

|  |  |
| --- | --- |
| What is the primary reason for today’s visit? |  Routine exam and cleaning   Dental Disease or Trauma  Consult for Tongue tie  Consult for ALF Therapy |

|  |  |
| --- | --- |
| Has your child ever been to the dentist? |  Yes  No |

|  |
| --- |
| **(If Yes)** |
| Previous/Present Dentist: |  | Date Last Exam: |  | Date Last X-Rays: |  |

|  |  |
| --- | --- |
| Do you think your child will react well to treatment? |  Yes No |

|  |  |
| --- | --- |
| Please describe any tips/tricks that will help our team provide a positive experience for your child’s visit: |  |

**DENTAL HABITS**

|  |
| --- |
| **Does your child currently… (check all that apply)** |
|  Suck Thumb/Finger |  Suck/Bite Lips |  Bite/Chew Nails |  Tongue Thrust |  Bottle Feed |
|  Use Pacifier |  Tongue/Cheek Chew |  Clench/Grind Teeth |  Mouth Breather |  Breast Feed |

**Birth History**

|  |
| --- |
| **(check all that apply)** |
|  Term < 37 weeks |  Induced labor |  Feeding schedule / day |  Vaginal Delivery | - Birth Weight |  |

|  |  |  |
| --- | --- | --- |
|  Breast feeding difficulties | :Assisted delivery/Cesarian  Labor time (in hours) |  Inability to self soothe  /day |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| Has growth and development occurred at a normal rate |  Yes No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child’s physician: |  | Phone: |  | Date Last Exam: |  |

|  |  |
| --- | --- |
| History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): |  |

|  |  |
| --- | --- |
| Current Medications: |  |

|  |  |
| --- | --- |
| **Is your child followed by a specialist?** |   Yes     No |
| If yes, please provide name and contact information: |  |

|  |
| --- |
| **Has your child been diagnosed and/or treated for any of the following… (check all that apply)** |
|  Blood Disorder/Anemia |  Tuberculosis (TB) |
|  Abnormal Bleeding/Hemophilia |  Asthma/Reactive Airway |
|  Immune Disorder/HIV/AIDS |  Tonsillitis |
|  Cancer/Tumor/Leukemia |  Congenital Birth Defects |
|  Heart Murmur/Defect/Surgery |  Premature/Low Birth Weight |
|  Epilepsy/Seizures/Convulsions |  Cleft Lip/Palate |
|  Cerebral Palsy |  Autism Spectrum |
|  Cystic Fibrosis |  ADD/ADHD |
|  Kidney Problems |  Eating Disorder |
|  Liver Disease/Jaundice/Hepatitis |  Speech Disorder |
|  Diabetes |  Vision Problems |
|  Sickle Cell Trait |  Hearing Problems |
|  Stomach/GI Disorders |  Deaf |
|  Other:  |  Mental/Cognitive/Social Delay |

|  |
| --- |
| **ALLERGIES:** |
|  Drug: |  |
|  Food: |  |
|  Seasonal |   |
|  Hives |   |
|  Latex |   |
|  Other (specify): |  |

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Synergy Dental Solutions may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Synergy Dental Solutions all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.