

## Medical & Dental History

These forms must be completed and returned before your child can receive dental care through the Smart Smiles program at Boys & Girls Clubs of Martinsville Henry County.

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Nickname \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ BGC/MHC Club member at \_\_\_\_\_ Club

My child attends the club \_\_\_ year round / \_\_\_ only during the school year / \_\_\_ only during the summer.

**I want my child to receive dental care through Smart Smiles. (Must complete remaining paperwork)**

**I do not want my child to receive dental care through Smart Smiles. (Stop now)**

My child has dental insurance through:

Medicaid/FAMIS/Smiles for Children **Policy/ID Number** \_\_\_\_\_

My child has no dental insurance

Private Dental Insurance \_\_\_ yes \_\_\_ no If yes, name of Carrier (Company) \_\_\_\_\_

**(If your child has private dental insurance, please speak with the Smart Smiles coordinator immediately.)**

Mother/Guardian's Name \_\_\_\_\_ Emergency Contact No. \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_ Emergency Contact No. \_\_\_\_\_

Parent's Marital Status: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single \_\_\_ Other \_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Name & ages of other children \_\_\_\_\_

Has your child had any of the following? (Please circle Yes or No for each medical condition)

Yes No Rheumatic Fever Yes No Allergies Yes No Hyperactivity

Yes No Kidney Disease Yes No Heart Disease Yes No Seasonal Hay Fever

Yes No Cerebral Palsy Yes No Liver Disease Yes No Heart Murmur

Yes No Hepatitis Yes No Brain Damage Yes No Frequent/Severe Headaches

Yes No Asthma Yes No Epilepsy/Seizures Yes No Hearing Disorder

Yes No Diabetes Yes No Bleeding Disorders Yes No Airway/Breathing Problems

Yes No Sickle Cell Yes No Autism Yes No Developmental Delay

Yes No Anemia Yes No Tuberculosis Yes No Birth Defect/Premature Birth

Yes No Pain in Jaws/TMJ Yes No Leukemia/Cancer Yes No High Blood Pressure

Does your child have any allergies? \_\_\_ yes or \_\_\_ no If yes, what is your child allergic to? \_\_\_\_\_

\_\_\_\_\_ What kind of reaction? \_\_\_\_\_

Is your child presently taking any medications? \_\_\_ yes or \_\_\_ no If yes, complete the following:

What? \_\_\_\_\_ Why? \_\_\_\_\_

Is your child taking any non-prescription supplements or herbs? \_\_\_ yes or \_\_\_ no If yes, please list:

Any additional medical or other information we should know? \_\_\_\_\_

**Has your child ever been to the dentist before? Yes / No If yes, when and where?**

If yes, did they have any issues or behavior problems (please circle)?

Anxiety Fear Unable to hold mouth open Would not stay in dental chair

Has your child had any of the following? (please circle)

Cavities Abscess Toothache/Pain Swelling Gum Problems Tartar Tumors/Growths in Mouth Broken Teeth

Trauma to mouth Snoring Mouth breathing Joint popping or pain

How long has your child had these problems? \_\_\_\_\_

How often & when does your child brush his/her teeth? \_\_\_\_\_

Does anyone help with brushing or flossing? \_\_\_\_\_

Has your child had dental x-rays? \_\_\_ yes \_\_\_ no When? \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_