Grins & Giggles Pediatric Dentistry

190 Curtis Parkway, Suite B Calhoun, GA 30701 Phone: 706-602-0448

Patient Information

1. Tell Us About Your Child

Child's Name _____
Nickname_____ [_]Male [_] Female
Siblings we treat _____
Birthdate ___/___/___ Child's Age _____
SS# _____
Home address _____
City_____ Zip_____
Phone_____
School_____ Grade____

2. Mother's Information

Name _____
Stepmother___ Guardian___ Birthdate __/__/__
Employer _____
Work # (____)_____
Home # (____)_____
Cellular Phone # (____)_____
Allow Text? [_] **Yes** [_] **No**
SS # _____ DL #_____
Single [_]Married [_]Separated [_]Widowed [_]Divorced [_]

3. Father's Information

Name _____
Stepfather___ Guardian___ Birthdate ___/___/___
Employer _____
Work # (____)_____
Home # (____)_____
Cellular Phone # (____)_____
Allow Text? [_] **Yes** [_] **No**
SS # _____ DL #_____
Single [_]Married [_]Separated [_]Widowed [_]Divorced [_]

4. Person Responsible for Account

Name _____
Relationship _____
Billing Address _____
_____
Home # (____) _____
Work # (____) _____
E-Mail _____

5. People Authorized to bring child to Appointments

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

6. Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # (____) _____
Group # (plan, local or Policy #) _____
Policy Holder's Name _____
Relationship to Patient _____
Birthdate ____/____/_____
Social Security # _____
Employer _____

7. Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # (____) _____
Group # (plan, local or Policy #) _____
Policy Holder's Name _____
Relationship to Patient _____
Birthdate ____/____/_____
Social Security # _____
Employer _____

***Please be advised it is the policy holder's responsibility to verify that all services are covered. In the event that x-rays, flouride, exams, sealants or fillings are downgraded we reserve the right to bill the policy holder for any non-covered services.**

Signature of parent/guardian:

_____

Date:__/__/____

Medical & Dental History

Patient's Name:_____ Date of Birth:__/__/____ [_] Male [_] Female
Child's Physician:_____ Phone:_____
Address:_____
Is the child currently under the care of a physician? __Yes __No
If yes, please explain:_____
_____
Please describe the child's current physcial health: __Good __Fair __Poor
Are Immunizations Current? __Yes __No
Please list all medications that the child is currently taking:_____
_____

Medical History- Has your child ever been treated for:			
Please circle one			
ADD/ADHD	**Yes** or **No**	Head Injury	**Yes** or **No**
Anemia	**Yes** or **No**	Heart Disease	**Yes** or **No**
Anxiety Disorder	**Yes** or **No**	Hepatitis Type__	**Yes** or **No**
Aids/HIV	**Yes** or **No**	High Blood Pressure	**Yes** or **No**
Tuberculosis	**Yes** or **No**	Kidney/Bladder/UTI	**Yes** or **No**
Cancer	**Yes** or **No**	Depression	**Yes** or **No**
Eye Problems	**Yes** or **No**	Migraine Headaches	**Yes** or **No**
Diabetes	**Yes** or **No**	Menstrual Disorder	**Yes** or **No**
Dizziness/fainting	**Yes** or **No**	Mononucleosis	**Yes** or **No**
ENT Disorder	**Yes** or **No**	Hemophilia Type__	**Yes** or **No**
Eating Disorder	**Yes** or **No**	Recent weight loss	**Yes** or **No**
Cerebral palsy	**Yes** or **No**	Sickle Cell	**Yes** or **No**
Hearing/Speech	**Yes** or **No**	Heart Murmur	**Yes** or **No**
Kidney Problems	**Yes** or **No**	Blood Transfusion	**Yes** or **No**
Hives	**Yes** or **No**	Cleft Palate	**Yes** or **No**
Liver Problems	**Yes** or **No**	Rheumatic Fever	**Yes** or **No**
Scarlet Fever	**Yes** or **No**	Scarlet Fever	**Yes** or **No**
Handicaps/disabilities	**Yes** or **No**	Autism	**Yes** or **No**

Dental History-Has your child ever had problems with:			
Please circle one			
Gum Infection	**Yes** or **No**	Sensitive Teeth	**Yes** or **No**
Color of teeth	**Yes** or **No**	Tooth Alignment	**Yes** or **No**
Thumb Sucking	**Yes** or **No**	Cavities/toothache	**Yes** or **No**
Does he/she brush their own teeth?	**Yes** or **No**	Does he/she use flouride toothpaste?	**Yes** or **No**
Does he/she floss their own teeth?	**Yes** or **No**	Does he/she go to bed with a bottle?	**Yes** or **No**
Was he/she breast or bottle fed? _____		Date Stopped: __/__/____	

Allergies:
Please list any allergies your child has:_____
_____
Surgeries:
Please list any surgeries your child has had including ear tubes and tonsillectomies:_____
_____

Consent to perform dental treatment: I authorize Grins & Giggles Pediatric Dentistry to perform the necessary dental procedures on my child including radiographs, local anesthia, and Nitrous oxide. I recognize that during the course of treatment, unforseen circumstances may necessitate changes in procedure from those discussed. I therefore, authorize and request the performance of any additional procedures that are deemed necessary to my child's oral health and well-being according to the professional judgement of the dentist at Grins & Giggles Pediatric Dentistry.
Signature:_____ Date: __/__/____

Receipt of notice of Privacy Practices written acknowledgements
I _____ have received a copy of Grins & Giggles Pediatric Dentistry's notice of privacy practices.
Signature:_____ Date: __/__/____

Photograph Consent
I, _____(parent name) authorize Grins & Giggles Pediatric Dentistry to utilize _____'s photographs for:
Check all that apply
[_] Publication (Facebook and/or educational purposes)
[_] Office use (patient records and account purposes)
Signature: _____ Date: __/__/____