

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 physical 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 anesthesia, and Nitrous oxide. I recognize that during the course of treatment, unforeseen 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:** __/__/____