Welcome!

thanks you for choosing our team for your child's dental care!

Patient Information

Patient Name: ________________________________ **Nickname:** _________________ **DOB:** ____________

Sex: ____ **Address:** _______________________________ **City:** ___________________ **Zip:** ____________

Whom may we thank for referring you? ◯ Friend ◯ Physician ◯ Dentist ◯ School/Daycare

◯ Internet ◯ Live in the area If we can thank them, what is their name: ___________________________

Guardian Information

Guardian (I)

Name: _____________________________________

Preferred Phone: _____________________________

Secondary Phone: ____________________________

Email: ______________________________________

Address (if different): _________________________

City _________________________ **Zip** __________

Best way to contact you: ◯ **Text** ◯ **Call** ◯ **Email**

Guardian (II)

Name: _____________________________________

Preferred Phone: _____________________________

Secondary Phone: ____________________________

Email: ______________________________________

Address (if different): _________________________

City _________________________ **Zip** __________

Best way to contact you: ◯ **Text** ◯ **Call** ◯ **Email**

Who is accompanying the child today? _______________________

Insurance Information

Primary Insurance

◯ Same as ◯ **Guardian I** ◯ **Guardian II**

Name of Insured Member: _______________________

DOB: __________ Relationship to patient: __________

Dental Insurance Co. ____________________________

Employer: _____________________________________

Subscriber ID or SS#: ____________________________

Secondary Insurance

◯ Same as ◯ **Guardian I** ◯ **Guardian II**

Name of Insured Member: _______________________

DOB: __________ Relationship to patient: __________

Dental Insurance Co. ____________________________

Employer: _____________________________________

Subscriber ID or SS#: ____________________________

Dental History

Dental Concerns

What is the primary reason for today's visit?:

◯ Cleaning/Exam ◯ Trauma/Dental Emergency ◯ Consult for Decay ◯ Referral for Behavior

Has your child ever been to the dentist?: ◯ Yes ◯ No

(if Yes) Previous/Present Dentist: _____________________ Estimated Last Visit Date: ____________________

Do you think your child will react well to treatment?: ◯ Yes ◯ No

Please list favorite hobbies, sports, TV shows, pets (and names), etc. to help us you're your child at ease:

____

Dental Habits **Please indicate all descriptions that CURRENTLY apply to the patient:**

- O Bite/Chew Nails
- O Bottle Fed
- O Breast Fed
- O Grinds or clenches teeth
- O Frequent Snacking
- O Frequent sore throats
- O Mouth Breather
- O Jaw Joint Pain/Clicking
- O Snores
- O Sucking habits
- O Tongue Thrust
- O Used or uses a Pacifier

Hygiene Routine

- O Fluoride Mouthwash
- O Brushing by Child: _____ /day
- O Fluoride Toothpaste
- O Brushing by Parent: _____/day
- O Fluoridated Water
- O Dental Floss: _____/week
- O Snack between Meals
- O Tongue Brushing

Medical History

Anything you would like to discuss with the doctor in private? ◯ Yes ◯ No

Please list your child's pediatrician or primary medical doctor: ____________________________________

Please discuss any serious medical problems the child experiences(ed): ____________________________________

Specific drugs or medications currently taken:____

Allergies? If yes, please list: ____

Has patient ever had any of the following conditions?

- O **NONE, my child has NEVER had any medical conditions.**
- O Acid Reflux
- O ADHD/ADD
- O Anemia
- O Asthma/**Respiratory** Disease
- O Autism Spectrum Disorder
- O Behavior Disorder
- O Bone/Joint/Muscle Problems
- O Cancer Type: _______________
- O Cerebral Palsy
- O Cleft Lip/Palate
- O Cold Sores/Canker Sores
- O Diabetes ◯Type 1 ◯Type 2
- O Developmentally Delayed
- O Eating Disorder
- O Epilepsy/Seizures
- O Eye/ Vision Problems
- O Genetic Syndrome/Disorder
- O Hearing Impairment
- O **Heart** Issue/ Surgery
- O Hemophilia/ **Bleeding Issues**
- O Hepatitis/Liver Disease
- O Immunizations Not Current
- O Immune Disorder/HIV/AIDS
- O **Implants**/Shunts/Pins/Screws
- O Kidney Disease Disorder
- O Metabolic Disorder
- O Premature Birth
- O Psychiatric Care
- O Sickle Cell Anemia/Trait
- O Sleep Apnea
- O Speech Disorder
- O Stomach/GI Disorders
- O Tonsillectomy/Adenoidectomy
- O Tuberculosis
- O Other (please explain): __________________________

I am the parent and/or legal guardian of the patient and there are no court orders in effect preventing me from giving consent. I confirm that the information provided above is accurate to the best of my knowledge. I am aware that I must inform GV Smiles of any changed to my child's medical history. I provide authorization for GV Smiles to perform any necessary dental services including, but not limited to, a comprehensive examination, cleanings, fluoride treatment, and any necessary dental treatment to maintain my child's oral health. I have been advised that x-rays may be necessary to properly diagnose dental disease and to detect pathology. I have an expectation that risks and benefits for all dental treatment will be explained. I understand the most common dental complications include, not are not limited to, pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth or surrounding tissues, development of a temporomandibular disorder, temporary or permanent numbness, and allergic reactions. I understand that GV Smiles 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. 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 GV Smiles all insurance payments unless 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, & attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian: ________________________ **Signature:** ________________________ **Date:** __________ **Dr:** ____