

Welcome to Great Grins Children's Dentistry, P.L.L.C.! So that we may provide your child with the best possible care please complete this new patient information form.

BACKGROUND INFORMATION

Child's name _____ Today's Date _____
Date of Birth _____
Child's Soc. Sec. # _____ Male _____ Female _____
Child's preferred name(nickname) _____
Child's residence _____ City _____ State _____ Zip _____
Hobbies _____
Likes _____ Dislikes _____
Siblings (with age) _____
Are siblings patients of Great Grins? Yes _____ No _____
Whom may we thank for referring you to our practice? _____
In case of emergency, whom (other than parent/ guardian) should we notify?
_____ Relationship _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Person financially responsible for this account _____ Phone# _____
Father/Guardian's name _____
Father's address (if different from child's) _____
Social Security # _____ Drivers license # _____
Marital Status: Single _____ Married _____ Divorced _____ Widow _____ Widower _____
Home phone # _____ Other phone # _____
Father's Employer _____ How long/position _____
Employer's Address _____ Business phone _____ Ok to call? _____
Mother/Guardian's name _____
Mother's address (if different from child's) _____
Social Security # _____ Drivers license # _____
Marital Status: Single _____ Married _____ Divorced _____ Widow _____ Widower _____
Home phone # _____ Other phone # _____
Mother's Employer _____ How long/position _____
Employer's Address _____ Business phone _____ Ok to call? _____
Who is the custodial parent / legal guardian? _____

DENTAL INSURANCE

Primary insured name _____ Date of birth _____ SS# _____
Name of insurance co. _____ Telephone of insurance co. _____
Address of insurance co. _____
Program or policy # _____ Group # _____

HEALTH HISTORY

DENTAL HISTORY- PLEASE ANSWER ALL QUESTIONS

What is the reason for your child's visit today? _____

Date of last dental visit _____ Last dental cleaning _____

What was done at the last dental visit? _____

Previous dentist's name _____

Address _____ City/State _____ Telephone _____

Any problems with previous dentists? Yes _____ No _____ Explain _____

How often has your child had dental examinations? _____

Does your child have any dental problems now? _____

If yes, please describe _____

MEDICAL HISTORY- PLEASE ANSWER ALL QUESTIONS

In your opinion, is your child healthy? Yes _____ No _____ if no, why not? _____

Who is your child's physician? _____ Phone _____

Address _____ City/State _____ Zip _____

Has your child been under the care of a medical doctor during the past two years? Yes _____ No _____

If yes, for what? _____

Has your child taken any medication or drugs during the past two years? Yes _____ No _____

If yes, please list name and dosage _____

Is your child currently taking any medications? Yes _____ No _____

If yes, what medications and for what condition(s) _____

Is your child **allergic** to any medication or substance? Yes _____ No _____ List _____

Is a parent **allergic** to any medication or substance? Yes _____ No _____ List _____

Indicate which of the following your child has or had. Please check "yes" or "no"

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Valley fever	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Cleft palate/lip	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine problems
<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	Drug/chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	STD's	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Persistent nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	RSV	<input type="checkbox"/>	<input type="checkbox"/>	Low birth weight/SIDS	Last Asthma attack: _____		
<input type="checkbox"/>	<input type="checkbox"/>	Allergies, if so, to what _____						
<input type="checkbox"/>	<input type="checkbox"/>	Other, please describe _____						

Is your child current with his/her immunizations? Yes _____ No _____

If no, why not? _____

Is there anything else about you or your child's health history that we should know? Yes _____ No _____

If yes, please describe _____

Do you wish for more privacy when discussing your child's health history? Yes _____ No _____

12 and older: Do you: Smoke or use chewing tobacco? Yes _____ No _____ Drugs? Yes _____ No _____

Alcohol? Yes _____ No _____

Teens: Are you pregnant? Yes _____ No _____ If so, how many months? _____ Nursing? Yes _____ No _____

Taking birth control pills? Yes _____ No _____

CONSENT AND RELEASE

Please note: It is the policy of Great Grins Children's Dentistry, P.L.L.C. not to allow parents to accompany their children into the treatment area when restorative treatment is being performed (ex. fillings). The primary purpose of such a policy is to allow our staff to develop a trusting, working relationship with your child. Experience has shown us that children actually do better without their parents in the treatment area. You are welcome to come into the treatment area for other visits (ex. cleanings).

ADDITIONAL TERMS

Cleaning/examination appointments canceled with less than 24 hours notice are subject to a \$50.00 cancellation charge and this charge must be paid before additional appointments may be scheduled. Missing a scheduled treatment appointment (ex. fillings/sedation) without a 48 hour notice or valid excuse may result in a \$50.00 charge or being refused further appointments. Arriving more than 10 minutes late for a scheduled appointment may result in the appointment being rescheduled, less treatment being performed or an increase in fees. Checks returned by the bank are subject to a \$20.00 processing charge and no further appointments will be scheduled unless payment is received in full prior to such appointments. Such payment must be by certified check. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of 1% per month (12% per year). Should the account be referred to for collection, you will be responsible for collection costs, together with court costs and reasonable attorneys' fees.

RELEASE: I authorize Great Grins Children's Dentistry, P.L.L.C. (Angela M. Wolfman, D.D.S. & Kedar S. Lele, D.D.S.) to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Great Grins Children's Dentistry, P.L.L.C., otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts and, if my insurance carrier does not pay the claim within 60 days, the claim becomes my responsibility. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions correctly and fully and to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will promptly notify you of any change in my child's health or use of medications.

Parent/Guardian signature _____ Date _____