Medical History reviewed by

_____

Welcome to Great Grins Children's Dentistry, P.L.L.C.

We are honored that you have entrusted your child's care to us. We take great pride in providing a comfortable experience and dental home for children and their families.

Patient Information

DOB_____

Child's Name _____ Nickname_____ Sex_____
First Middle Last name

Child's residence _____ City_____ State ____ Zip _____

Siblings (with age) _____

Are siblings patients of Great Grins? **Y N**

Is child adopted? **Y N** If yes, does child know? **Y N**

Who is accompanying child at this visit? _____

Whom may we thank for referring you to our practice? □ Internet □ Facebook □ Website □ Pediatrician □ Insurance

□ Other_____

Emergency Information – Other than Parent or Guardian

Name _____ Phone # _____ Relationship to child _____

Responsible Party Information

Parent one/Legal Guardian one

Name _____
First Middle Last

DOB: ____/____/____ Relationship to child _____

Do you have legal custody of child? **Y N**

SS# _____ Drivers License # _____

Address (if different from child's)

_____

Marital status: Married Single Separated Divorced

Home ph. # _____Cell # _____

Work Ph. # _____ Ok to call? **Y N**

Employer _____

Occupation _____

Parent two/Legal Guardian two

Name _____
First Middle Last

DOB: ____/____/____ Relationship to child _____

Do you have legal custody of child? **Y N**

SS# _____ Drivers License # _____

Address (if different from child's)

_____

Marital status: Married Single Separated Divorced

Home ph. # _____Cell # _____

Work Ph. # _____ Ok to call? **Y N**

Employer _____

Occupation _____

Person financially responsible for this account: _____

Email address: _____

(You will receive text message and/or email reminders for appointment confirmations)

Dental Insurance Information (not needed if card provided)

Primary

Policy holder's name _____ Policy holder's SS# _____ DOB _____/_____/_____

Name of Insurance Co. _____Group # _____ Subscriber # _____

Insurance Co. Address _____ Insurance Co. ph # _____

Secondary

Policy holder's name _____ Policy holder's SS# _____ DOB _____/_____/_____

Name of Insurance Co. _____Group # _____ Subscriber # _____

Insurance Co. Address _____ Insurance Co. ph # _____

Medical History

Is your child in good health? **Y N** If no, why not? _____

Child's Physician? _____ Phone # _____

Address_____ City _____ State _____ Zip _____

Has your child ever had any of the following:

Y N	Y N	Y N	Y N	Y N
□ □Anemia	□ □Dizziness	□ □Heart problem	□ □Liver Disease	□ □Seasonal allergies
□ □Arthritis	□ □Drug/ Chemotherapy	□ □Heart valves	□ □Low birth weight	□ □Seizures
□ □Artificial joints	□ □Emotional problems	□ □Hemophilia	□ □Low blood pressure	□ □Sickle cell anemia
□ □Asthma (Last attack____)	□ □Endocrine problems	□ □Hepatitis A/B/C	□ □Mononucleosis	□ □STD's
□ □Behavioral problems	□ □Epilepsy	□ □High blood pressure	□ □Persistent nose bleeds	□ □Tuberculosis
□ □Bladder problems	□ □Excessive bleeding	□ □HIV/AIDS	□ □Radiation therapy	□ □Tumors
□ □Blood transfusion	□ □Fainting spells	□ □Hyperthyroidism	□ □Rheumatic fever	□ □Ulcers
□ □Bruise easily	□ □Frequent colds	□ □Hypothyroidism	□ □Ringing in ears	□ □Valley fever
□ □Cancer	□ □Headaches	□ □Kidney problems	□ □RSV	□ □Vision problems
□ □Cleft palate/lip	□ □Heart murmur			
□ □Diabetes				

□ Other, please describe _____

Does child need premedication prior to dental treatment? **Y N** Why? _____

Is your **child allergic** to any medications or substances? **Y N** List _____

Is your child currently taking any medications (to include **dietary supplements, vitamins or herbal medications**)? **Y N**
Please give medication, dose and reason:

_____

Has your child been under the care of a medical doctor during the past two years? **Y N**

If yes, for what? _____

Is child current with his/her immunizations? **Y N** If no, why not _____

Do you wish for more privacy when discussing your child's health history? **Y N**
Teens: Are you pregnant? **Y N** Taking birth control medication? **Y N**

Dental History

Is this your child's first visit to a dentist? **Y N**

If no, how long since the last visit? _____

Previous dentist's name (if applicable): _____

Reason for leaving dentist?_____

Do you have any dental concerns or questions?

_____

Do any of the following apply to your child?

Frequent snacking?	**Y N**	Breast-feeding?	**Y N**
Sleeping with a bottle?	**Y N**	Pacifier use?	**Y N**
Tooth grinding?	**Y N**	Thumb sucking?	**Y N**
Sippy cup use?	**Y N**	Fingers in mouth?	**Y N**

Has your child experienced any unfavorable reaction from previous medical or dental care? **Y N**
Explain:_____

Dental care:

How often does your child brush? _____ Floss? _____

Is brushing/flossing supervised? **Y N**

By whom ?_____

Does your child use a mouth rinse? **Y N**

Is your child taking fluoride supplements? **Y N**

Does your child use fluoridated toothpaste? **Y N**

Authorization and Release

The information I have given is correct to the best of my knowledge. I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. 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 understand that is my responsibility to inform this office of any changes in my child's medical status or use of medications. 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.

Please note: If your child needs restorative treatment (ex fillings), we ask that you allow us to develop a trusting, working relationship with your child by not remaining in the room during treatment. You can accompany your child back to allow him or her to become comfortable and then we will ask you to wait in the reception area. Experience has shown us that children actually do better without their parents in the treatment area. You are more than welcome to come back for other routine visits such as cleanings.

Parent/Legal Guardian Signature: _____ Date: _____