PEDIATRIC HEALTH INFORMATION

ABOUT YOUR CHILD

Child's Name: _____
Last Name First M.I.

Nickname: _____ ☐ Male ☐ Female

Date of Birth: _____ Age: ____ SSN: _____

Home Address: _____

_____
City State Zip Code

Home Phone: ( ) _____

School: _____ Grade: _____

Sibling's Name: _____

PARENT INFORMATION

Mother's Name: _____

Employer: _____

Work Phone: _____

Father's Name: _____

Employer: _____

Work Phone: _____

Emergency Contact: _____

Phone/Cell: _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group Plan/Policy No: _____

DENTAL INSURANCE INFORMATION

SECONDARY CARRIER

Insured's Name: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group Plan/Policy No: _____

DENTAL HISTORY

Please check the questions below if your child have/had:

- ☐ Are your child's immunizations current?
- ☐ Has your child had trouble from previous dental care?
- ☐ Does your child have pain in his/her jaw joint (TMJ)?
- ☐ Has any type of local anesthetic ever been administered to your child?
- ☐ Does your child have bad breath?
- ☐ Does your child have frequent sores on lips or mouth?
- ☐ Is your child experiencing any pain or sensitivity in his/her mouth or teeth?
- ☐ Lip sucking / biting
- ☐ Nail biting
- ☐ Breathing through mouth
- ☐ Clenching/grinding teeth
- ☐ Thumb/finger sucking
- ☐ Used pacifier
- ☐ Tongue/cheek biting
- ☐ Tongue thrust
- ☐ Breast fed
- ☐ Frequent bottle use / sleeps with bottle at night

Is there any other problem not covered in this section that you would like to discuss? ☐

If yes, please specify: _____

_____

** MEDICAL HISTORY LOCATED ON THE BACK SIDE **

WE'RE SO GLAD YOU HEAR! TELL US MORE!

What is the primary reason for your visit today? _____

Who referred you to our office? _____

Date of last dental visit? _____ Name of dentist? _____

PATIENT NAME: _____ **Date of Birth:** _____

MEDICAL HISTORY

MEDICAL HISTORY - Certain illnesses and drugs may have direct effect on the oral cavity and consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary to have the following information:

Does your child have or has your child ever had the following? If yes, Please check the questions below:

- Allergies ☐
- Anemia ☐
- Blood Disorders ☐
- Any abnormal or prolonged bleeding, or easily bruised ☐
- Asthma or other respiratory ailment ☐
- Cancer ☐
- Congenital heart disease ☐
- Heart Murmur ☐
- Convulsions ☐
- Seizures ☐
- Fainting ☐
- Diabetes or blood sugar problems ☐
- High blood pressure ☐
- Low blood pressure ☐
- Immune compromised HIV AIDS ☐
- Kidney problems ☐
- Bladder problems ☐
- Liver problems ☐
- Thyroid problems ☐
- Rhuematic fever or rheumatic heart disease ☐
- Tuberculosis ☐
- Pneumonia ☐
- Speech, learning, or hearing disorders ☐
- Hospitalized since birth ☐
  Please Specify: _____
- Presently taking any medications ☐
  Please Specify: _____
- Childhood illnesses ☐
  Please Specify: _____
- Any medical condition/problems not stated above that should be brought to our attention ☐
  Please Specify: _____

Parent or Guardian Signature	Date:	Doctor's Signature	Date:
X		**X**	

(name of child)

I hereby certify that the information provided on this form is true and correct in its entirety. Since _____ is a minor patient, signed permission from a parent or guardian is required before any necessary dental treatment can be initiated. By signing this form, I hereby grant such permission. I acknowledge my responsibility for any professional fees incurred for dental services provided to my child. I authorize Great Expressions Dental Centers to release my child's dental records to the insurance carrier(s) named on the reversed side for insurance purposes:

Signed: X _____ Date: _____