GREAT GRINS
Children's Dental Specialists®

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THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Full Name _____ Age _____
Sex_____Date of Birth _____ Name Child Prefers to be Called _____
Patient's Address _____ Home Phone _____
Street City State Zip
Father's Name _____ Birth date _____ Email Address _____
His Address _____ Social Security # _____
Street City State Zip
Home Phone _____ Cell Phone _____ Work Phone _____
Where Employed _____
Mother's Name _____ Birth date _____ Email Address _____
Her Address _____ Social Security # _____
Street City State Zip
Home Phone _____ Cell Phone _____ Work Phone _____
Where Employed _____
Phone Numbers for confirmation of appointment _____
With whom does patient live _____
Other children in family_____Names and ages _____
Dental Insurance? yes___ no___ Company _____
Child's Physician _____ Family Dentist _____
Whom may we thank for referring you to our office _____

HEALTH HISTORY

	Yes	No
Is your child in good health?	_____	_____
Is this your child's first dental visit?	_____	_____
Is your water supply fluoridated (city water)	_____	_____
Is your child up to date with immunizations?	_____	_____

Date of your child's last medical examination: _____
Is your child a thumb/finger sucker? _____ Use a pacifier?_____
If your child was bottle fed, at what age was it discontinued? _____

Check any of the following that may pertain to your child:

____Rheumatic Fever	____Bleeding disorder	____Lung problem	____Mental Disorder
____Heart Condition	____Cerebral palsy	____Brain injury	____Emotional disorder
____Speech disorder	____Liver	____Epilepsy	____Tuberculosis
____Hearing disorder	____Kidney	____Hepatitis	____Sickle Cell Anemia
____Vision disorder	____Asthma	____Diabetes	____Autism
____Nervous disorder	____Allergies	____Retardation	____Other

	Yes	No
Is your child presently taking any medicine? _____ (Name of Medication)	____	____
Has your child experienced any unfavorable reaction to medicine? (Such as penicillin, aspirin, xylocaine)	____	____
Is your child presently undergoing medical treatment	____	____
Has your child ever been hospitalized since birth?	____	____
If so, Date:_____ Reason _____		
Has your child ever had a general anesthetic?	____	____
If so Dates:_____ Reasons _____	____	____
Has your child ever had an unfavorable experience in a dental office?	____	____

Date and place of your child's last dental care _____
Does your child have a toothache? _____
Purpose of this appointment _____
Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment _____

PARENT OR GUARDIAN bringing patient to our office is responsible to us for payment of account.

Date _____ _____
Signature of parent or guardian