GibbsDentistry

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CHILDREN'S MEDICAL INFORMATION

Today's date: _____

(complete both sides)

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell us about your child

Child's full name: _____ Nickname: _____

Birthdate: _____Age: _____ SS#: _____ ☐Male ☐Female

School: _____Grade: _____

Home #: _____Email: _____

Communications Preference: ☐E-Mail ☐Text

Home address: _____

Who is accompanying this child today?

Name: _____Relation: _____

Do you have legal custody of this child? ☐Yes ☐No

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____Last visit date: _____

Parent's marital status: ☐single ☐married ☐widowed ☐divorced ☐partnered ☐separated

Mother's information:

Name: _____ Birthdate:_____

Email: _____

Cell #: _____Home #: _____

Employer: _____Work #: _____

SS #: _____ DL #: _____ St: _____

Father's information:

Name: _____ Birthdate:_____

Email: _____

Cell #: _____Home #: _____

Employer: _____Work #: _____

SS #: _____ DL #: _____ St: _____

Person responsible for account:

Name: _____ Birthdate:_____

Email: _____

Cell #: _____Home #: _____

Employer: _____Work #: _____

SS #: _____ DL #: _____ St: _____

Who is responsible for making appointments?

Name: _____

Cell #: _____Home #: _____

PRIMARY Dental Insurance:

Insurance Co. name: _____Orthodontic coverage? ☐Yes ☐No

Phone #: _____ Group/Policy #: _____ ID #: _____

Policy owner's name: _____Relation: _____ Birthdate:_____

Policy owner's employer: _____

SECONDARY Dental Insurance:

Insurance Co. name: _____Orthodontic coverage? ☐Yes ☐No

Phone #: _____ Group/Policy #: _____ ID #: _____

Policy owner's name: _____Relation: _____ Birthdate:_____

Policy owner's employer: _____

Reason for visiting **Gibbs Dentistry** today? _____

Has the child ever had a serious/difficult problem associated with previous dental work? ☐Yes ☐No

Is the child's water fluoridated? ☐Yes ☐No Is the child taking fluoridated supplements? ☐Yes ☐No

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? ☐Yes ☐No

Does the child brush their teeth daily? ☐Yes ☐No Floss daily? ☐Yes ☐No

Is the child currently under the care of a physician? ☐Yes ☐No

Child's Physician: _____Phone #: _____

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Has the child ever taken Fosamax, Boniva, Actonel, or any other bisphosphonate/antiresorptive bone medication? ☐Yes ☐No

If yes, please explain:_____

Is the child allergic to: ☐Latex ☐Metals/Nickel ☐Plastic ☐Additional allergies: _____

Has the child ever had any of the following medical problems?

Abnormal bleeding	☐Yes ☐No	Congenital heart defect	☐Yes ☐No	Hepatitis	☐Yes ☐No
ADD/ADHD	☐Yes ☐No	Convulsions/Epilepsy	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Any hospital stays	☐Yes ☐No	Diabetes	☐Yes ☐No	Kidney/Liver problems	☐Yes ☐No
Any operations	☐Yes ☐No	Handicaps/Disabilities	☐Yes ☐No	Rheumatic/Scarlet fever	☐Yes ☐No
Artificial bones/joints	☐Yes ☐No	Hearing impairment	☐Yes ☐No	Sickle cell disease/traits	☐Yes ☐No
Asthma	☐Yes ☐No	Heart murmur	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cancer	☐Yes ☐No	Hemophilia	☐Yes ☐No		

Please add any serious medical problems: _____

Does/did the child experience any of the following?

Lip sucking/biting	☐Yes ☐No	Mouth breather	☐Yes ☐No	Speech problems	☐Yes ☐No
Tongue thrust	☐Yes ☐No	Nail biting	☐Yes ☐No	Nursing bottle habits	☐Yes ☐No
Thumb/finger sucking	☐Yes ☐No	Clenching/grinding teeth	☐Yes ☐No		

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform **Gibbs Dentistry** of any changes in my child's medical status.
I authorize **Gibbs Dentistry** to perform the necessary dental services my child may need.

Parent/Guardian name *(please print):* _____

Parent/Guardian signature: _____ Date: _____

The Parent/Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved by **Gibbs Dentistry**.