GibbsDentistry
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Patient Information:

Name_______________________________ Preferred Name____________________

Date of Birth______________________ ☐ Male ☐ Female

Address___________________________ City______________ State_____ Zip______

Home Phone______________ Cell Phone________________ Email____________________

Emergency Contact_____________________________ Phone Number________________

Communication Preference: ☐ E-Mail ☐ Text

Who is accompanying child today? Name______________________ Relationship______________

Mother's Information:

Name_______________________________ Date of Birth______________________

Address___________________________ City______________ State_____ Zip______

Home Phone______________ Cell Phone________________ Work Phone______________

Email_______________________________ Employer__________________________

Father's Information:

Name_______________________________ Date of Birth______________________

Address___________________________ City______________ State_____ Zip______

Home Phone______________ Cell Phone________________ Work Phone______________

Email_______________________________ Employer__________________________

Dental Insurance:

Primary Dental Insurance _________________________ Policy Holder__________________

Date of Birth____________ SS Number____________Employer_______________________

Secondary Dental Insurance_________________________ Policy Holder__________________

Date of Birth____________ SS Number____________Employer_______________________

Physician________________________________ Phone Number____________________

Pharmacy________________________________ Phone Number____________________

Signature of Parent or Guardian________________________________ Date______________

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

Is the child under a physician's care now? O Yes O No If Yes____

Has the child ever been hospitalized or had a major operation? O Yes O No If Yes____

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

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

Does the child brush their teeth daily? O Yes O No Floss Daily? O Yes O No

Is the child taking any medications, pills, or drugs? O Yes O No If Yes____

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Has the child ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? O Yes O No If Yes____

Is the child allergic to any of the following: O Latex O Metals/Nickel O Plastic Additional allergies__________________

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Does/did the child have any of the following? **Check all that apply.**

AIDS/HIV Positive		Cancer		Hearing Impairment		Leukemia	
ADD/ADHD		Congenital Heart Defect		Heart Murmur		Rheumatic/Scarlet Fever	
Abnormal Bleeding		Convulsions/Epilepsy		Hemophilia		Sickle Cell Disease	
Artificial Bones/Joint		Diabetes		Hepatitis		Tonsillitis	
Asthma		Handicaps/Disabilities		Kidney/Liver Problems		Tuberculosis	

Has the child had any serious illness not listed? O Yes O No If Yes____

Does/did the child experience any of the following? **Check all that apply.**

Lip Sucking/Biting		Thumb/Finger Sucking		Nail Biting		Speech Problems	
Tongue Thrust		Mouth Breather		Clenching/Grinding Teeth		Nursing Bottle Habits	

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 preform the necessary dental services my child may need.

Signature of Patient, Parent or Guardian____ Date____________________

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