



**TELL US ABOUT YOUR CHILD:**

Patient's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Nickname \_\_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Male or Female

Patient's Address \_\_\_\_\_  
Street City State Zip

Who is accompanying the child today? \_\_\_\_\_

Other siblings or relatives seen by our office \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Last visit date \_\_\_\_\_ Did your child have difficulty cooperating? \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

**PARENT'S INFORMATION:**

Mother  Step Mother  Guardian

Name \_\_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ e-mail \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Name of Parent/Guardian's dentist \_\_\_\_\_

Father  Step Father  Guardian

Name \_\_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ e-mail \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Parents Marital Status**

Single  Married  Widowed  Divorced  Separated

**PRIMARY DENTAL INSURANCE:**

Insurance Co. Name: \_\_\_\_\_ Group # \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ I.D. # \_\_\_\_\_

Policy Owner's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_

**SECONDARY DENTAL INSURANCE:**

Insurance Co. Name: \_\_\_\_\_ Group # \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ I.D. # \_\_\_\_\_

Policy Owner's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Owner's Employer \_\_\_\_\_



Purpose of today's visit (also list any concerns) \_\_\_\_\_

Is your child's water fluoridated?  Y  N

Does your child have any oral habits? Lip Sucking  Y  N Nail Biting  Y  N
Pacifier  Y  N Thumb/Finger Sucking  Y  N

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

- Abnormal Bleeding, ADD / ADHD, Anemia, Allergies, Autism, Cancer, Asthma, Congenital Heart Defect, Convulsions, Diabetes, Down Syndrome, Drug Allergies, Epilepsy, Frequent ear infections, Handicaps/Disabilities, Hearing Impairment, Heart Murmur, Hemophilia, Hepatitis, HIV / AIDS, Juvenile Arthritis, Kidney / Liver Problems, Mononucleosis, Rheumatic / Scarlet Fever, Sickle Cell Disease or Traits, Speech Problems, Surgeries, Hospital stays, Is your child currently under the care of a psychiatrist/psychologist?

Please list all drugs your child is currently taking \_\_\_\_\_

Please list any significant medical problems your child has had not listed above \_\_\_\_\_

Is your child adopted?  Y  N

Is there anything you would like to discuss with Dr. Gillham in private? \_\_\_\_\_

In an effort to improve communications with our patients, The Kids Dentist will be e-mailing , texting or leaving automated appointment reminder messages. If you are interested in being part of this service, please choose one option and enter your information below.

e-mail address \_\_\_\_\_ Cell Phone # \_\_\_\_\_
Home phone # \_\_\_\_\_
(your phone provider may charge text/data usage fee)

I hereby grant permission to the staff of this office for the administration of such anesthetics and the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. The medical and dental information as answered on this form is correct to the best of my knowledge. I will notify this office of any changes in my child's dental or medical history.

I understand I am financially responsible for payment of any services rendered as well as broken appointment fees and all late payment service charges. Should I have dental insurance, I also understand that obtaining insurance coverage and benefit information as well as keeping up with the ever changing policies of my unique plan is my responsibility.

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_