Gentle Dental
Family Dentistry

Thank you for choosing our practice to meet your child's dental needs!

Patient's First Name & Middle Initial	Last Name	Social Security #
Address and Apartment #	City	Zip Code
Parent's Email		Date of Birth
Home Phone # Parent's Cell Phone #		☐ Male ☐ Female

Who can we thank for referring you? (Google, Insurance Website) _____

Primary Insurance

Name of Policyholder	Employer	Social Security # of Policyholder
Group #	Date of Birth of Policyholder	Phone # on Insurance Card
Member ID	Insurance Company	Relationship to Patient

Secondary Insurance

Name of Policyholder	Employer	Social Security # of Policyholder
Group #	Date of Birth of Policyholder	Phone # on Insurance Card
Member ID	Insurance Company	Relationship to Patient

Primary Care Physician

Name of Doctor	Phone #
Is your child being treated by your doctor for any illness? (Diabetes, Cancer, Asthma)	

Dental Health History

He/She brushes _____ times/day.	Bleeds when flossing ☐ Yes ☐ No	Difficulty Chewing ☐ Yes ☐ No	Had prolonged bleeding ☐ Yes ☐ No	Sores/Lumps in Mouth ☐ Yes ☐ No
He/She flosses _____ times/day.	Uses bristles that are ☐ Hard ☐ Med. ☐ Soft	Clench/Grind Teeth ☐ Yes ☐ No	Problems with dental work ☐ Yes ☐ No	Head/Neck/Jaw Injuries ☐ Yes ☐ No
Bite Lips/Cheeks ☐ Yes ☐ No	Sweet/Sour Sensitivity ☐ Yes ☐ No	Hot/Cold Sensitivity ☐ Yes ☐ No	Difficulty Opening/Closing ☐ Yes ☐ No	Discomfort in TMJ ☐ Yes ☐ No
Uses tobacco? ☐ Yes ☐ No	Uses alcohol? ☐ Yes ☐ No	Uses drugs not prescribed by his/her own doctor? ☐ Yes, _____ ☐ No		Abuses drugs/alcohol ☐ Yes ☐ No

Do you have an allergy or hypersensitivity to any of the following:

Latex ☐ Yes ☐ No	Antibiotics (Penicillin, Amoxicillin, Tetracycline, Other)	Other: (Medications)
Pain medication (Aspirin, Codeine, Local Anesthetics, Other)		

Ever had surgery of any kind? (Brain, heart, donated/received an organ, joint replacement, ACL, broken bone)

_____

Does your child take any meds? If many, please speak with an Administration Team Member for a comprehensive list.

_____

Any respiratory problems? (Asthma, Emphysema, COPD)	Any allergies? (Seasonal, food)
Any psychiatric problems or illnesses? (Anxiety, Depression)	Ever been recommended to take pre-appointment meds?

Medical History - Please indicate if your child has, or has had, any of the following:

Congenital Heart Defect ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Heart Attack ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Artificial Valves ☐ Yes ☐ No	Joint Replaced ☐ Yes ☐ No
Blood Pressure Issues ☐ Yes ☐ No	Cancer ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Abnormal Bleeding ☐ Yes ☐ No	Stomach Issues ☐ Yes ☐ No	Liver Problems ☐ Yes ☐ No
Cardiac Pacemaker ☐ Yes ☐ No	Autism ☐ Yes ☐ No	Pins or Plates ☐ Yes ☐ No	Blood Transfusion ☐ Yes ☐ No	Stents or Shunts ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Sexually Trans. Disease ☐ Yes ☐ No	HIV/AIDS ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No
Hepatitis Type_____ ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Fainting Spells ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Sinus Problems ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No

Targeted Health Questions - Does your child:

Take a blood thinner? ☐ Yes ☐ No	Take a bisphosphonate? ☐ Yes ☐ No	Have an autoimmune disease? ☐ Yes, _____ ☐ No	Have Ulcerative Colitis? ☐ Yes ☐ No
Is there anything you'd like us to know to make your child's visit more comfortable?			

Emergency Contact

Name:	Relationship to You:	Phone #:

Medical History Affirmation - <u>NOTE: CHILDREN MUST BE ACCOMPANIED BY A PARENT TO EVERY APPOINTMENT</u>

I certify that I have read and understand the above information and questions. I affirm that I have answered the questions accurately and that providing incorrect information, knowingly or accidentally, may be dangerous to my child's health. There are no court orders now in effect that prohibit me from signing this consent. I understand I am financially responsible for all charges incurred on his/her account and I agree to pay. I also authorize Gentle Dental Family Dentistry to disclose my child's health information to the insurance company(ies) under which my child is covered in order to determine benefits and obtain payment.

Parent/Guardian's Signature _____ *Date* _____

Medical History Affirmations For Upcoming Years

Parent/Guardian's Signature _____ *Date* _____

Parent/Guardian's Signature _____ *Date* _____

Parent/Guardian's Signature _____ *Date* _____