GRANGER PEDIATRIC DENTISTRY

CHILDS NAME: ____ Male Female
Birthdate:_______________Age:_____ Child lives with: (circle) Father Mother Both Other
Home Address:____
City, State, Zip Code____

FATHER:_________________________Home Phone:______________Cell Phone:_____________
Social Security Number:___________________________Birthdate:________________________
Father's Employer:______________________________Work Phone:________________________
Home address if different than child's:____

MOTHER:________________________Home Phone:______________Cell Phone:_____________
Social Security Number:___________________________Birthdate:________________________
Mother's Employer:______________________________Work Phone:_______________________
Home address if different than child's:____
Marital status of parents: (circle one) Married Single Divorced Separated Widowed

EMAIL_______________________________ **REFERRED BY:**_____________________________

Name of Legal Guardian:_______________________________Phone:______________________
EMERGENCY CONTACT NOT LIVING WITH YOU:_______________________________________
Address:____
Home Phone:_______________Cell Phone:________________Work Phone:__________________

PRIMARY DENTAL INSURANCE:
Name:______________________________
Phone:___________Policy #_____________
Policy Holder Name:____________________

SECONDARY DENTAL INSURANCE:
Name:________________________________
Phone:__________Policy #________________
Policy Holder Name:_______________________

NAME OF PHYSICIAN:______________________________ **PHONE:**_________________________

HEALTH HISTORY INFORMATION:

ADHD	Y	Seizures	Y	Radiation Treatment	Y
AIDS	y	GI System	Y	Respiratory Treatment	Y
Allergies	Y	Endocrine System	Y	Respiratory Problems	Y
Anemia	Y	Fainting	Y	Rheumatic Fever	Y
Artificial Joints	Y	Hearing/Sight	Y	Autism	Y
Asthma	Y	Heart Murmur	Y	Tuberculosis	Y
Blood Disease/ Disorder	Y	Heart Condition	Y	Down Syndrome	Y
Blood Transfusion	Y	Head Injury	Y	Vomiting/Diarrhea	Y
If yes date________		Multiple Ear Infections	Y	Allergies/Adverse Reaction to Medication	Y
Behavioral/ Learning Disorder	Y	Kidney Disease	Y	If yes what type of medication?________________ ________________________	
Breathing/Lung Problems	Y	Liver Disease	Y	Frequent infections	Y
Cancer/Tumor	Y	Mental Disorder	Y	What type_________________ _________________________	
Congenital Birth Defects	Y	Mental/Physical Developmental Delay	Y	Any other medical conditions not listed__________________ _________________________	
		Pregnant	Y		
		Due Date_________			

Has your child ever been diagnosed with any medical health problems, conditions, or syndromes? If yes, please describe____

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If there are other persons you would like to give permission to bring your child/children to Granger Pediatric Dentistry and to make dental treatment decisions on your behalf, please list:
Name:______________________________ Relationship to Child:___________________________
Name:______________________________ Relationship to Child:___________________________

I have read the above and have answered them to the best of my knowledge. Once an appointment has been made, that time is reserved specifically for your child. We reserve the right to charge a $30 fee for a no show appointment or last minute cancellation. We ask that you give us at least a 24 hour notice to cancel or reschedule to avoid our cancellation fee. Three (3) missed/broken appointments, without at least 24 hours prior notification, may prevent further scheduling by this office.

Signature____Date_________________________