GATE CITY DENTAL

Child's Full Name: _____ Name child goes by: _____

Date of Birth: _____ Age: _____ Male or Female: _____

Address: _____ City/State: _____ Zip: _____

Home Number: _____ Current School: _____ Grade: _____

How did you hear about us? _____

PARENT/LEGAL GUARDIAN

Parent/LG Name: _____Relationship to Patient: _____

Home Address (if different from patient) _____ Home #: _____

Cell #: _____ Email: _____

DENTAL INSURANCE

Insurance Company: _____Subscriber ID: _____

Policy holder: _____Relationship to Patient: _____

Policy holder birthdate: _____Soc. Sec. #: _____

DENTAL INFORMATION:

Is this your child's first dental visit? _____
If not, date of last visit: _____
Were x-rays taken? _____
Has your child had a bad experience in a dental office? _____
Did your child nurse or use a bottle after 12 months? _____
Did/does your child nurse or use a bottle during the night? _____
Do you assist your child's brushing? _____
How often do they brush: _____

Does your child have any habits(thumb sucking, pacifier)
If so, list: _____

Does your child drink juice or soda? _____
If so, how much a day? _____
Has child ever had a toothache? _____
Has child ever had a dental injury? (bumped or chipped tooth, bruised lip?) Explain: _____

HEALTH HISTORY

Physician Name: _____ Phone #: _____

Please list any medications your child is currently taking:

_____

Please list any allergies (including medication allergies) :

_____

Please mark if your child has been treated for any of the following:

ADHD/ADD __	Developmental Delays __	Kidney/Bladder Disease __
Anemia __	Diabetes __	Liver Disease/Hepatitis __
Anxiety/Depression __	Eating Disorder __	Malignancies __
Asthma __	Epilepsy/Seizures __	Rheumatoid Arthritis __
Autism/Asperger's __	Fainting __	Sensory Issues __
Cerebral Palsy __	Heart Problems __	Speech Delays __
Chronic Sinusitis __	Heart Murmurs __	Thyroid Problems __
Deaf/Blind __	HIV/AIDS __	Tuberculosis __

Please list any surgeries or hospitalizations:

_____

Additional Medical Information:

_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I hereby authorize payment directly to Gate City Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

What is your preference for receiving statements: _____ Paper(mailed) _____Email _____Text

_____

Signature of Parent/Legal Guardian **Date**