



Drs. Gillespie and Martin, P.A.
C O S M E T I C & G E N E R A L D E N T I S T R Y

WELCOME to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

PATIENT	RESPONSIBLE PARTY
Patient's Name _____	Name _____
Preferred Name _____	Relationship to patient _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Home Phone _____	Home Phone _____ Work Phone _____
SS# _____	Social Security # _____ Birthdate _____
Birthdate _____ Gender _____	Employer _____
Child Lives with: Both Parents _____ Mother _____ Father _____ Other _____	Occupation _____ How Long _____
Whom do we call to confirm appointment _____ Phone # _____	SPOUSE'S INFORMATION
PERSON TO CALL IN AN EMERGENCY	Name _____
Name _____	Employer _____
Phone # _____	Work Phone _____

PRIMARY DENTAL INSURANCE	ADDITIONAL DENTAL INSURANCE
Policyholder's Name _____	Policyholder's Name _____
Policyholder's Address _____	Policyholder's Address _____
Relationship to patient _____ Policyholder's Birthdate _____	Relationship to patient _____ Policyholder's Birthdate _____
Policyholder's Soc. Sec. # _____	Policyholder's Soc. Sec. # _____
Policyholder's Employer _____	Policyholder's Employer _____
Insurance Company Name _____	Insurance Company Name _____

AUTHORIZATION AND RELEASE
<p>I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners.</p> <p>Authorization To Pay Benefits To Dentist: I hereby authorize payment directly to Drs. Gillespie & Martin, P.A., of the Dental Benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.</p> <p>A credit report may be obtained according to services provided.</p> <p>I have received or read "Notice of Privacy Practices" for this office. (Also located in each treatment room and available on request.</p>
<p>SIGNATURE OF PARENT/GUARDIAN _____ DATE _____</p>

CHILD'S NAME _____ DATE _____

HEALTH HISTORY

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Please circle if your child experienced any of the following:

- | | | | |
|---------------------|-----------------------|----------------|------------------------------|
| Allergies | Heart Murmur | Epilepsy | Tumor History |
| Anemia | Thyroid Disease | Fainting | Cancer |
| Leukemia | Hearing Disorder | Jaundice | Radiation Treatment |
| Asthma or Hay Fever | Speech Disorder | Hepatitis | Date of Last Treatment _____ |
| Heart Disease | Diabetes | HIV Virus/AIDS | Chemotherapy |
| Kidney Disease | Liver Disease | Tuberculosis | Hemophilia |
| Blood Disorder | Seizures | Sinus Trouble | |
| Rheumatic Fever | Psychiatric Treatment | | |
| Depression | Eating Disorders | | |

Is your child allergic or sensitive to penicillin or ANY other drugs or medicine? If yes, please list _____

Does your child have any disease, condition or problem not listed above? If yes, please explain _____

Name of child's physician _____ City/State/Phone _____

Is your child under the care of a physician now? Reason _____

Has your child ever been hospitalized? Reason & date _____

Is your child taking any medication? If yes, please list _____

DENTAL HISTORY

What is your main concern about your child's dental health? _____

Is this your child's first visit? _____ If no, date of last dental visit _____

What was done? _____ Were x-rays taken? _____

Has your child ever complained about a problem, or had any unhappy dental experiences? _____

Please explain _____

- | | |
|---|--------------------|
| Any injury to mouth, teeth or head? | YES _____ NO _____ |
| Any mouth habits? (circle)
(thumbsucking, nail biting, mouth
breather, nursing bottle habits, etc.) | YES _____ NO _____ |
| Any unusual speech habits? | YES _____ NO _____ |
| Orthodontic appliances worn now or ever? | YES _____ NO _____ |
| Does your child brush his/her teeth daily? | YES _____ NO _____ |
| Do you assist your child with tooth brushing? | YES _____ NO _____ |
| Is dental floss used? | YES _____ NO _____ |
| Is fluoride taken in any form? | YES _____ NO _____ |

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please explain:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____