Giglio dental
FAMILY & COSMETIC

WELCOME

Tell Us About Your Child

Today's Date: _____ ❑ Male ❑ Female

Child's Home Phone #: (____)_____ Child's Age: _____

Child's Birthdate: ____/____/____ Social Security #: _____

Child's Name: _____
Last First M

Nickname: _____

Child's Home Address: _____
Street

_____
City State Zip

Who Is Accompanying The Child Today?

Name _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Is the child adopted? ❑ Yes ❑ No

Whom may we Thank for referring you? _____

Other Siblings seen by us: _____

_____

_____

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

Mother: ❑ Step Mother ❑ Guardian Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____

Father: ❑ Step Father ❑ Guardian Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____

Insurance Inbformation

Primary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone#: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address _____
Street City State Zip

Secondary Insurance

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone#: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address _____
Street City State Zip

Continued on back

Medical History

Child's Physician: _____ Phone #_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

Please list all drugs that the child is currently taking: _____

Please list all drugs that cause the child allergic reactions: _____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No Explain: _____

Has the child had/experienced any of the following:

Y N Abnormal Bleeding	Y N Diabetes	Y N Low Blood Pressure
Y N AIDS / HIV+	Y N Epilepsy	Y N Lupus
Y N Anemia	Y N Handicaps / Disabilities	Y N Measles
Y N Allergies	Y N Hearing Impairment	Y N Mitral Valve Prolapse
Y N Any Hospital Stays / Operations	Y N Heart Murmur	Y N Mononucleosis
Y N Asthma	Y N Hemophilia	Y N Rheumatic Fever
Y N Blood Transfusion	Y N Hepatitis	Y N Scarlet Fever
Y N Cancer	Y N High Blood Pressure	Y N Sickle Cell Anemia
Y N Chicken Pox	Y N Hives	Y N Skin Rash
Y N Congenital Heart Defect	Y N Kidney Problems	Y N Tonsillitis
Y N Convulsions	Y N Liver Problems	Y N Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/Ed: _____

_____

Dental History

Is the child currently in pain? ❑Yes ❑No What is the primary reason for today's visit? _____

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑Yes ❑No

Has the child experienced problems with previous dental work? ❑Yes ❑No

Is the child's water fluoridated? ❑ Yes ❑ No Is the child taking fluoridated supplements? ❑Yes ❑No

Does the child brush his / her teeth daily? ❑ Yes ❑ No Floss his / her teeth daily? ❑Yes ❑ No

Previous / Present Dentist: _____ Date of Last Visit: _____

Why did you leave your previous dentist? _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my childs medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. Giglio all insurance benefits otherwise payable to me. I understand that I am ultimately responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent or guardian Date