



Local Smile Co.  
PEDIATRIC DENTISTRY

WELCOME TO THE OFFICE OF DR. ANDREA PINNICK GAMBLE

DENTISTRY FOR INFANTS, CHILDREN, AND ADOLESCENTS

CHILD PATIENT FORM

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_  Male  Female  
Birthday \_\_\_\_\_ Age \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Referred to Our Office by \_\_\_\_\_

PARENT INFORMATION

Relationship \_\_\_\_\_  
Guardian #1 Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Number \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Number \_\_\_\_\_

Relationship \_\_\_\_\_  
Guardian #2 Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Number \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Number \_\_\_\_\_

Who does the child live with?  
 Guardian 1       Guardian 2       Guardian 1 and 2  
Other \_\_\_\_\_

WHO IS ACCOMPANYING THE PATIENT TODAY?

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Do you have legal custody of this child?       Y       N

PERSON RESPONSIBLE FOR ACCOUNT

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Primary Number to Confirm Appointments \_\_\_\_\_

Cell Phone Consent

"I consent to the dental practice using my cell phone number to (choose one or both) CALL or TEXT regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time."

Cell Phone Number \_\_\_\_\_ Initials \_\_\_\_\_

Telephone Message Consent

"I understand brief messages from the dental practice may be left on my home/cell phone or with anyone who answers the telephone at my home unless I have provided the practice with alternative instructions for communication."

Telephone Number for Messages \_\_\_\_\_ Initials \_\_\_\_\_

PRIMARY INSURANCE

Insurance Co. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. Phone \_\_\_\_\_  
Group/Policy# \_\_\_\_\_  
Name of Policy Owner \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_

SECONDARY INSURANCE

Insurance Co. \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. Phone \_\_\_\_\_  
Group/Policy# \_\_\_\_\_  
Name of Policy Owner \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Employer \_\_\_\_\_

# NEW PATIENT INFORMATION CONTINUED

## SOCIAL AND BEHAVIOR

Has the child had a previous unfavorable or fearful dental or medical experience?  Y  N  
If yes, please describe \_\_\_\_\_  
How would you best rate your child's temperament? \_\_\_\_\_  
Child's Favorite Color/Toy/Movie \_\_\_\_\_

## DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_  
Has the child been to a dentist before?  Y  N  
Date of Last Dental Visit \_\_\_\_\_  
Date of Last Dental X-rays \_\_\_\_\_  
Previous Dentist \_\_\_\_\_  
How may we help make this visit a positive experience for your child?  
\_\_\_\_\_  
Has the child experienced any injuries to the teeth, mouth or jaws?  Y  N  
Does the child have any of the following habits?  
 Suck Thumb/Finger  Breast Feeding-Until Age \_\_\_\_\_  
 Suck/Bite Lips  Bottle Feeding-Until Age \_\_\_\_\_  
 Bite/Chew Nails  Clench/Grind Teeth  
 Use Pacifier  Mouth Breather

Does the child brush his/her teeth daily?  Y  N  
Is the child's toothpaste fluoridated?  Y  N  
Does the child floss his/her teeth daily?  Y  N  
Does the child use mouthwash?  Y  N  
Do you brush your child's teeth?  Y  N  
What type of water does the child drink?  
 Tap  Filtered  Reverse Osmosis  Bottled  
Does the child take fluoride supplements?  Y  N  
How many snacks between meals per day? \_\_\_\_\_

## CHILD'S PHYSICIAN

Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Date of Last Visit \_\_\_\_\_

## HEALTH HISTORY

Are immunizations current?  Y  N  
Has your child been diagnosed and/or treated for any of the following?  
Abnormal Bleeding/Hemophilia  Y  N  
ADD/ADHD  Y  N  
Allergies or Hay Fever  Y  N  
Asthma/Reactive Airway Disease  Y  N  
Autism/ASD  Y  N  
Bone/Joint Problems  Y  N  
Cancer/Tumor/Leukemia  Y  N  
Cleft Lip and/or Palate  Y  N  
Congenital Heart Defect  Y  N  
Diabetes  Y  N  
Disabilities/Special Needs  Y  N  
Hearing/Vision Impairment  Y  N  
Heart Disease/Murmur  Y  N  
HIV+/AIDS/Immune Disorder  Y  N  
Kidney/Liver Problems  Y  N  
Rheumatic/Scarlet Fever  Y  N  
Sickle Cell Disease/Trait  Y  N  
Seizures/Epilepsy/Convulsions  Y  N  
Stomach/GI Disorders  Y  N  
Tuberculosis  Y  N

Does the child have a history of the following?  
 Premature Birth  Serious Illness  
 Hospitalization/Operation  Allergies to Medications  
 Allergies to Latex  Food Allergies

List Allergies \_\_\_\_\_  
Current Medications \_\_\_\_\_

Is there anything else regarding your child's physical, mental, or emotional health that you feel should be brought to the doctor's attention?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Our office is committed to the highest standards of infection control mandated by OSHA, the CDC, and the ADA. I understand the information I have given is true and correct to the best of my knowledge, that it will be held in the strictest of confidence. I grant this office permission to provide my child's dental treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete treatment, including diagnostic radiographs. I understand it is my responsibility to inform the office of any changes in my child's health or medications.

\_\_\_\_\_  
Name of Parent or Guardian Signature Date  
\_\_\_\_\_  
Doctor's Signature Date