

grin pediatric dentistry
6225 Chapel Hill Blvd
Plano, TX 75093

Child's Full Name: _____ Preferred Name: _____
Date of Birth: _____ Age: _____ Weight: _____ Gender: _____
Street: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ E-mail: _____
School: _____ District: _____ Grade: _____
Name(s) and age(s) of sibling(s): _____
Have sibling(s) been seen in this office? Yes _____ No _____
Mother's Name: _____ Father's Name: _____
Favorite Playmate, Pet, Toy, Hobby, or Sport: _____

How or from whom did you learn about our practice? _____

Is this your child's first visit to a Dentist? Yes _____ No _____
If, not please share with us why you wish to make a change. _____
_____ Date of last visit _____ Dentist _____
How would you describe your child's previous medical or dental experience?

Please discuss your expectations and desires regarding your child's dental care.

Does your child have a history of any oral habits? (Mouth breathing, thumb sucking, etc.)
If so, please explain: _____

Does your child have regular medical examinations?
Physician _____ Date of last exam _____
Is your child taking any medication(s) right now? Yes _____ No _____
If so, please explain: _____
Has your child experienced any unfavorable reaction to any medication(s)? Yes _____ No _____
If so, please explain: _____
Does your child have any known physical or medical conditions? Yes _____ No _____
If so, please explain: _____
Is your child adopted? Yes _____ No _____
Please indicate any condition(s) your child has had:
___ Chicken Pox ___ Convulsions ___ Rheumatic Fever ___ Small Pox ___ Kidney
___ Epilepsy ___ Measles ___ Heart Condition ___ Anemia ___ Disease
___ Nervousness ___ Asthma ___ Blood Disorder ___ Tumors ___ Other
___ Diabetes ___ Mumps ___ Emotional Problems ___ Cerebral Palsy
Please note any special information about your child: _____

Family History

Father's Full Name: _____ Preferred Name: _____
Home Address if different from child's: _____
Phone #'s: Home: _____ Work/Cell: _____ Fax: _____
Occupation: _____ Employer: _____ how long? _____
Social Security #: _____ Driver's License #: _____ Date of Birth: _____

Mother's Full Name: _____ Preferred Name: _____
Home Address if different from child's: _____
Phone #'s: Home: _____ Work/Cell: _____ Fax: _____
Occupation: _____ Employer: _____ how long? _____
Social Security #: _____ Driver's License #: _____ Date of Birth: _____

Child's parents are: Married: _____ Divorced: _____ Separated: _____
If parents do not live together, with whom does the child live? _____
Name of friend or relative who may be contacted in case of emergency:
_____ Relationship _____ Phone _____

Do you have dental insurance? Yes _____ No _____

If so, please complete the following information:

Insured's Name: _____

Group Number: _____

Name of dental insurance company: _____

Claim filing address of your dental insurance: _____

Phone # of your dental insurance company: _____

IT IS OUR POLICY TO INFORM YOU THAT PAYMENT OF FEES FOR PROFESSIONAL SERVICES IS EXPECTED AT THE TIME OF TREATMENT BY THE PARENT OR GUARDIAN IN ATTENDANCE WE ACCEPT PAYMENT BY CHECK OR CASH. FOR THOSE WISHING THE CONVINIENCE OF EXTENDED PAYMENT PLANS, WE ALSO ACCEPT PAYMENT BY MASTERCARD OR VISA.

BECAUSE THIS CHILD IS A MINOR IT BECOMES NECESSARY THAT PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL TREATMENT IS BEGUN. AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEES FOR PROFESSIONAL SERVICES RENDERED ON BEHALF OF THIS CHILD.

SIGNATURE _____ DATE _____

RELATIONSHIP TO CHILD _____