GROWING SMILES
PEDIATRIC DENTISTRY

Patient Information

Who may we thank for referring you?_____ Date:_____/_____/_____

Child's Name:_____ Birthdate___/___/____ Age____ Sex: M F
First M.I. Last

Nick Name _____ Child's interests_____ Pets_____
School_____ Grade_____

Has our office previously seen any siblings? Y N Name/Age of child's
Brothers_____Sisters_____

Dental Information

Is this your child's first dental visit? Y N Previous Dentist_____ Last visit_____
How do expect your child to react to this visit? Excellent Good Fair Poor Unsure
How many times a day does your child brush? _____ Is your child assisted? Y N
How many times a day does your child floss? _____ Is your child assisted? Y N
Does your child have any of the following habits **(please circle)**:
1. Finger sucking 3. Mouth Breather 5. Thumb sucking
2. Tongue Thrusting 4.Teeth Grinding 6. Pacifier
Does your child receive fluoride from **(please circle)**:
1. Vitamins 3. Toothpaste 5. Tablets/Drops Dosage_____
2. Water supply 4. Rinse/Gel
Was your child bottle fed? Y N Until what age?_____ Breast fed? Y N Until what age?_____
Has your child had any toothaches recently? Y N Please explain_____
Has your child ever had any injuries to the mouth, jaw, teeth or head? Y N Please describe_____
Has your child had a bad experience in another dental office? Y N Please describe_____
Do you have any specific concerns or questions you would like to discuss? _____

Medical Information

Child's physician_____ Date of last exam_____
Is your child in good health? Y N
Are your child's immunizations up to date? Y N
Is your child presently being treated for any condition? Y N Please explain_____
Has your child been hospitalized or had surgery (including out-patient surgery)? Y N
Please explain_____
Has your child experienced or is there a family history of anesthetic related problems including malignant hyperthermia? Y N
Describe the problem_____
What family member was affected, and what is the relationship to your child_____
Is your child currently taking any medications? Y N Please list_____

Medical Information

Has your child ever been diagnosed with any of the following? (Please **circle** Yes or No to each)

No Yes	ADD with Hyperactivity	**No Yes**	Chronic Headaches	**No Yes**	Heart Murmur
No Yes	ADD without Hyperactivity	**No Yes**	Cleft Lip/Palate	**No Yes**	Hepatitis
No Yes	AIDS	**No Yes**	Convulsions/Seizures	**No Yes**	Intellectually Disabled
No Yes	Anemia	**No Yes**	Diabetes	**No Yes**	Kidney Disease
No Yes	Asthma	**No Yes**	Emotional Disturbance	**No Yes**	Leukemia
No Yes	Autism	**No Yes**	Traumatic Experience	**No Yes**	Liver Disease
No Yes	Birth Defects	**No Yes**	Excessive Bleeding	**No Yes**	Nutritional Deficiency
No Yes	Blood Transfusions	**No Yes**	Bleeding Disorder	**No Yes**	Oral Ulcers
No Yes	Bone/Joint Problems	**No Yes**	Excessive Gagging	**No Yes**	Orthopedic Problems
No Yes	Brain Injury	**No Yes**	Eye Problems	**No Yes**	Premature Birth
No Yes	Bruising Easily	**No Yes**	Fainting/Dizziness	**No Yes**	Rheumatic Fever
No Yes	Cancer/Malignancies	**No Yes**	Growth/Development problems	**No Yes**	Scoliosis
No Yes	Cerebral Palsy	**No Yes**	Hearing Problems	**No Yes**	Speech Problems
No Yes	Child Abuse	**No Yes**	Ear Infections	**No Yes**	Tuberculosis
No Yes	Chronic Adenoid/Tonsil Infections	**No Yes**	Heart Disease	**No Yes**	Other:_____

To any **YES** answers above, please explain: _____

Please circle if your child is allergic to any of the following

Penicillin/Amoxicillin Latex Other: **(please list)** _____
Medications (please list) _____ Pollen/Dust
Metals Food Allergies/Dyes **(please list)**_____

Family Information

Parent/Guardian Name_____ Birthdate_____/_____/_____
Relationship to the child **(please circle)** Mother/Father Step-Mother/Step-Father Guardian (relation) _____

Mailing address_____
Street/PO Box City State Zip Code
Home phone (_____) _____ Work phone (_____)_____ Cell phone (_____)_____
Employer_____ Occupation_____
Social Security Number _____
Email Address _____

Parent/Guardian Name_____ Birthdate_____/_____/_____
Relationship to the child **(please circle)** Mother/Father Step-Mother/Step-Father Guardian (relation) _____

Mailing address_____
Street/PO Box City State Zip Code
Home phone (_____)_____ Work phone (_____)_____ Cell phone (_____)_____
Employer_____ Occupation_____
Social Security Number _____
Email Address _____

Legal Custody is with **(please circle)**: Mother Father Both Parents Guardian(s)
Child lives with: **(please circle)**: Mother Father Both Parents Guardian(s)
Natural parents marital status **(please circle)**: Married Single/Never Married Separated Divorced Widowed

Emergency Contact (Specify someone who **does not live** in your household.)
Family (or close friend) Name: _____ Relation to Patient:_____
Address: _____ Phone: (_____)_____

If Legal Guardians are NOT the parents, we require copy of current court documents for our records.

Primary Dental Insurance

Insurance Name_____ Phone #_____ Group/Policy #_____
Mailing address_____ Subscribers Name _____
Subscribers Employer_____ Subscribers SS# or Id#_____ Subscribers Birthdate ___/___/_____

Secondary Dental Insurance

Insurance Name_____ Phone #_____ Group/Policy #_____
Mailing address_____ Subscribers Name _____
Subscribers Employer_____ Subscribers SS# or Id#_____ Subscribers Birthdate ___/___/_____

AUTHORITY TO TREAT / TERMS, CONDITIONS AND FINANCIAL INFORMATION

I hereby authorize Gilbert A Trujillo DDS and/or Kellie McGinley DDS to treat the above patient using restorative and patient management techniques that are acceptable and proper. I understand that a treatment plan with associated fees will be discussed fully with the parent / guardian prior to the beginning of any treatment. I also understand that the treatment plan and fees could change depending upon the time elapsed since the initial examination or as a result of diagnostic image findings not obtained at the initial examination. In addition, I authorize release of this information to the patient's medical doctor of record. Dental insurance is an agreement between my family's insurance carrier and the policy holder. I authorize payment directly to the dentist. I agree to accept responsibility for the full payment of service, regardless of insurance benefits; therefore, I recognize statements will come to me, at my address. I also understand that this office will only send statements to me, and cannot be involved in third party situations. I acknowledge the above information is true and correct.

Signature of Parent / Guardian _____ Date _____ Relation to Patient _____
Print Name of Parent / Guardian _____