*This is a fillable form. Please download and **TYPE** your information.*

iGrin Children's Dentistry

Welcome!

We are pleased to welcome you and your child to our practice!
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.
We look forward to working with you in maintaining your child's dental health.

Patient Information

Date _____ *SS/HIC/Patient ID #* _____ *Birthdate* _____

Name of Minor/Child _____
Last Name *First Name* *Middle Initial*

Nickname _____ *Sex* ☐ *M* ☐ *F* *Age* _____

Hobbies _____

Home Address _____
Street Name *City* *State* *Zip*

Mailing Address _____
Street Name *City* *State* *Zip*

Phone _____ *Cell Phone* _____ *Work Phone* _____

School Name _____ *School Phone* _____

Person Financially Responsible _____

Whom may we thank for referring you? _____

Insurance

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ *Work Phone* _____
If different than phone numbers above

Email _____

Employer _____

Soc. Sec. # _____ *Birthdate* _____

Do you have dental insurance coverage for minor/child? ☐ *Y* ☐ *N*

Plan Name _____ *Phone* _____

Address _____

Group # _____ *Policy #* _____

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ *Work Phone* _____
If different than phone numbers above

Email _____

Employer _____

Soc. Sec. # _____ *Birthdate* _____

Do you have dental insurance coverage for minor/child? ☐ *Y* ☐ *N*

Plan Name _____ *Phone* _____

Address _____

Group # _____ *Policy #* _____

Is your child eligible for Medical Assistance? ☐ *Y* ☐ *N* *Child's Medical Assistance ID #* _____

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Dental History

Date of last visit to a dentist _____ *For what service?* _____

	YES	NO		YES	NO
Has child complained of dental problems?	☐	☐	*Is fluoride taken in any form?*	☐	☐
Does child brush teeth daily?	☐	☐	*Any injuries to mouth, teeth, head?*	☐	☐
Does child use floss every day?	☐	☐	*Any unhappy dental experiences?*	☐	☐
Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc?				☐	☐

Medical History

Minor/Child's Physician _____ *City/State* _____ *Phone* _____

Date of last physical examination _____ *Results* _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving an medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever have surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has Minor/Child had any history of or difficulty with any of the following? If yes, please select.

☐ *AIDS / HIV*	☐ *Convulsions*	☐ *Hepatitis*	☐ *Sinus Problems*
☐ *Anemia*	☐ *Diabetes*	☐ *Kidney Disease*	☐ *Thyroid Disease*
☐ *Asthma*	☐ *Drug / Alcohol Abuse*	☐ *Liver Disease*	☐ *Tuberculosis*
☐ *Bladder Problems*	☐ *Epilepsy*	☐ *Measles*	☐ *Other* _____
☐ *Cancer*	☐ *Fainting*	☐ *Mononucleosis*	_____
☐ *Cerebral Palsy*	☐ *Hearing Problems*	☐ *Mumps*	_____
☐ *Chicken Pox*	☐ *Heart Problems*	☐ *Rheumatic Fever*	

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Emergency Contact

In the event of an emergency, whom should we contact?

Name _____ *Relationship* _____ *Phone* _____

Name _____ *Relationship* _____ *Phone* _____

Authorizations

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ *all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.*

The above-named doctor may use my minor's/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is complete.

_____ _____

Signature of Parent, Guardian or Personal Representative *Date*

_____ _____

Please print name of Parent, Guardian or Personal Representative *Relationship to Patient*

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Update *(To be completed at a later visit)*

Has there been any change in patient's health since last dental appointment? ☐ *Y* ☐ *N*

If yes, please describe _____

_____

Is patient taking any new medications? ☐ *Y* ☐ *N*

If yes, please list _____

_____

_____ _____

Signature of Parent, Guardian or Personal Representative *Date*

_____ _____

Signature of Dentist *Date*

864.606.0006 1860 OLD FURNACE RD., BOILING SPRINGS, SC 29316 GRIN@iGRIN.COM iGRIN.COM