

Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.



Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____

Apt. / Condo # _____

City

State

Zip



General Information

Who is accompanying the child today?

Name: _____ Relation: _____

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

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

City

State

Zip

Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City

State

Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City

State

Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____



Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment 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

Continued on Back



Dental History

Why did you bring the child to the dentist today? _____

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? _____ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

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

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

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

Aside from items listed, please list all drugs/things that the child is allergic to: _____

Yes No Latex

Yes No Metals/Nickel

Yes No Plastic



Medical History

Has the child experienced the following medical problems?

- | | |
|--|---|
| ☐ Y ☐ N Abnormal Bleeding / Hemophilia | ☐ Y ☐ N Hearing Impairment |
| ☐ Y ☐ N ADD/ADHD | ☐ Y ☐ N Heart Murmur |
| ☐ Y ☐ N AIDS/HIV+ | ☐ Y ☐ N Hepatitis |
| ☐ Y ☐ N Anemia | ☐ Y ☐ N High Blood Pressure |
| ☐ Y ☐ N Any Hospital Stays/Operations? | ☐ Y ☐ N Hives |
| ☐ Y ☐ N Artificial Bones/Joints/Valves | ☐ Y ☐ N Kidney Problems |
| ☐ Y ☐ N Asperger Syndrome | ☐ Y ☐ N Liver Problems |
| ☐ Y ☐ N Asthma | ☐ Y ☐ N Low Blood Pressure |
| ☐ Y ☐ N Autism | ☐ Y ☐ N Lupus |
| ☐ Y ☐ N Cancer | ☐ Y ☐ N Measles |
| ☐ Y ☐ N Chicken Pox | ☐ Y ☐ N Mitral Valve Prolapse |
| ☐ Y ☐ N Congenital Heart Defect | ☐ Y ☐ N Mononucleosis |
| ☐ Y ☐ N Convulsions | ☐ Y ☐ N Prosthetics |
| ☐ Y ☐ N Diabetes | ☐ Y ☐ N Rheumatic Fever |
| ☐ Y ☐ N Epilepsy | ☐ Y ☐ N Scarlet Fever |
| ☐ Y ☐ N Exposed to HIV, but Neg. | ☐ Y ☐ N Skin Rash |
| ☐ Y ☐ N Handicaps/Disabilities | ☐ Y ☐ N Tuberculosis (TB) |

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

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

Does/did the child experience any of the following?

- | | |
|--|---|
| ☐ Y ☐ N Breast Fed | ☐ Y ☐ N Nursing Bottle Habits |
| ☐ Y ☐ N Chewing on Objects | ☐ Y ☐ N Speech Problems |
| ☐ Y ☐ N Clenching/Grinding Teeth | ☐ Y ☐ N Thumb/Finger Sucking |
| ☐ Y ☐ N Lip Sucking/Biting | ☐ Y ☐ N Tongue/Cheek Biting |
| ☐ Y ☐ N Mouth Breather | ☐ Y ☐ N Tongue Thrust |
| ☐ Y ☐ N Nail Biting | ☐ Y ☐ N Used Pacifier |

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Signature of Dentist

Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Sandra Grzybicki to use and disclose protected health information about me or my child to carry out treatment, payment and healthcare operations. Dr. Grzybicki's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Grzybicki reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Dr. Grzybicki may call my home (or other alternative location), email or leave a message on voicemail in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my child's clinical care. With this consent, Dr. Grzybicki may mail to my home (or other alternative location) any items that assist the practice in these operations, such as appointment reminder cards and patient statements. By signing this form, I am consenting to Dr. Grzybicki's use and disclosure of my protected health information to carry out healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Grzybicki may decline to provide treatment to me or my child.

This consent is signed by patient or legal representative (or parent if child is under the age of 18):

X _____ Date: _____

Patient Name: _____

I authorize disclosure of any of the patient's medical records to the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____