GRAYSON PEDIATRIC DENTISTRY
2594 Loganville Hwy
Suite 106, Grayson, GA 30017
PH: (678) 682-9819
FAX: (678) 823-7260
Email:info@mydentaldoctor.com

GWINNETT PEDIATRIC DENTISTRY
2650 Lawrenceville Suwanee Rd
Suite 104, Suwanee, GA 30024
PH: (678) 799-7675
FAX: (678) 999-2963
Email:info@mydentaldoctor.com

PATIENT INFORMATION

Child's Name ____
Last Name *First Name* *Middle Initial*

Male Age ______ Birth date ___________ Nickname _______________

Female Email Address ____

Home Add ____
Street Apt # City State Zip Code

Mailing Add ____
Street Apt # City State Zip Code

Home Phone #_______________ Mom Cell #____________________ Dad Cell # ______________________________

Does your child have Georgia Medicaid/Peachcare? Yes No ID#__________________________________

Whom may we thank for referring you? Internet Yellow Pages Magazine School Direct Mailer
Another patient, friend or Dental Office __________________________

Who is Accompanying the child today? ____

INSURANCE/PARENT'S INFORMATION

Father Step Father Guardian	Mother Step Mother Guardian
Name___________________________	Name___________________________
Address (if different from patient) _______________	Address (if different from patient) _______________
Home Phone___________________ (If different from above)	Home Phone___________________ (If different from above)
Work Phone ___________________ (If different from above)	Work Phone ___________________ (If different from above)
Employer ______________________	Employer ______________________
Social Security # ______________	Social Security # ______________
Birth date ___________	Birth date ___________
Do you have dental insurance coverage for a minor/child? Yes No	Do you have dental insurance coverage for a minor/child? Yes No
Insurance Co.__________________	Insurance Co.__________________
Phone # _______________________	Phone # _______________________
Claims Address ________________	Claims Address ________________
Group # _______________________	Group # _______________________
Policy/I.D. # __________________	Policy/I.D. # __________________

DENTAL HISTORY

Last visit to a dentist ___________ Last Cleaning/Fluoride ____________ Last X-Rays ___________

Has child complained about dental problems? Yes No
Does child brush teeth daily? Yes No
Does child floss every day? Yes No
Is fluoride taken in any form? Yes No
Any injuries to mouth, teeth, head? Yes No
Any unhappy dental experiences? Yes No

Any mouth habits? *thumb sucking* *nail biting* *mouth breathing* *pacifier* *sleeping with bottle*

Other (please explain) ____

NAME AND PHONE NUMBER OF PREVIOUS DENTIST:____

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MEDICAL HISTORY (page 2)

Child's Name_______________________________

Child's Physician ___________________________ **City/State** __________________ **Phone** ___________________

Date of last physical examination ___________ **Current Medical Conditions** ________________________________

List of ALLERGIES (*LATEX* etc) ____

	Yes	No	
Has child ever been diagnosed with heart murmur?			**Is SBE prophylaxis required?** ________________
Is child receiving any medication or drugs?			**List Medications** _____________________
Has child ever been hospitalized?			**If so, why?** ____________________________
Has child ever had surgery?			**List surgeries**____________________________
Is there excessive bleeding when cut?			**Handicaps/Disabilities** ___________________

HAS CHILD EVER HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE

ADD/ADHD	Cerebral Palsy	Hearing Impairment	Mononucleosis
AIDS/HIV	Chicken Pox	Heart Murmur	Mumps
Anemia (Sickle cell or Low Iron)	Congenital Heart Defect	Hepatitis	Rheumatic Fever
Asthma	Convulsions/Seizures	Hemophilia	Sinus Problems
Artificial Heart Valves	Diabetes	Kidney/Liver Disease	Thyroid Disease
Autism	Drug/Alcohol Abuse	Learning Disability	Tuberculosis
Bladder Problems	Epilepsy	Measles	Cancer/Tumors
Fainting	Psychological Problems (example:DD/communication skillsdisorders)		

Other (please explain)____
Additional Notes:____
____

EMERGENCY CONTACT

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

Name ______________________ **Relationship** __________________ **Phone #** ______________

Name ______________________ **Relationship** __________________ **Phone #** ______________

CONSENT FOR TREATMENT

The information that I have given is correct and completed 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 am the LEGAL GUARDIAN of the patient. I authorize Dr. Asha/authorized associates/staff to perform the necessary dental procedures including, but not limited to the use of Nitrous Oxide (laughing gas), Lidocaine (Novacaine-like), and any necessary xrays on my child. PROCEDURES WILL ALWAYS BE DISCLOSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian Signature ________________________________ **Date** ___________________

FINANCIAL AGREEMENT

- **We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.**
- **ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.**
- **If the insurance company doesn't pay within a reasonable amount of time, it is required that you pay the balance due.**
- **Your insurance card must be presented at every visit. If there is no insurance card then payment (cash, check, or credit card) is expected at the time of service.**
- **I hereby authorize payment directly to provider, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.**
- **A fee will be charged to your account if there is a history of broken appointments with less than 48 hours notice.**

PARENT/GUARDIAN SIGNATURE ______________________________ **DATE**_________________

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Acknowledgement of Receipt of Notice of Privacy Practices

(You may refuse to sign this acknowledgement)

I, ___________________________________, have received a copy of this office's Notice of Privacy Policy.

Please Print Parent's Name: ____

Signature:____

Date:______________________________

Patient Name(s):____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)

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