



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!

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.

1 ABOUT YOUR CHILD

Name: _____
Nickname: _____
Birthdate: ____ / ____ / ____ Male Female
Special interests, sports or hobbies: _____
Home address: _____
Apt/Condo# _____ City _____ State _____ Zip Code _____
Home phone: (____) _____
Referred by: _____
Email: _____

2 ABOUT YOU

Parent 1 / Guardian (First, Middle, Last) _____
Home Address (if different than child's) _____
City _____ State _____ Zip Code _____
Phone: _____ | _____ | _____
Home Work Cell
Employer: _____
Employer's Address: _____
City _____ State _____ Zip Code _____
Parent 2 / Guardian (First, Middle, Last) _____
Home Address (if different than child's) _____
City _____ State _____ Zip Code _____
Phone: _____ | _____ | _____
Home Work Cell
Employer: _____
Employer's Address: _____
City _____ State _____ Zip Code _____

3 PRIMARY INSURANCE

Insurance Company Name: _____
City _____ State _____ Zip Code _____
Insurance Company Phone: _____
Group # / Policy #: _____
Subscriber's Name: _____
Relationship: _____
Birthdate: ____ / ____ / ____
Subscriber's # or assigned ID#: _____
Subscriber's Employer or Company Name: _____

SECONDARY INSURANCE

Insurance Company Name: _____
City _____ State _____ Zip Code _____
Insurance Company Phone: _____
Group # / Policy #: _____
Subscriber's Name: _____
Relationship: _____
Birthdate: ____ / ____ / ____
Subscriber's # or assigned ID#: _____
Subscriber's Employer or Company Name: _____





Child's Name: _____

1 DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? Yes No
 If yes, the approximate date of last visit : _____
 Are there any dental problems that you are aware of at present?
 Yes No If yes, please explain : _____
 Does your child brush his / her teeth daily? Yes No
 Please rate your child's oral health : Good Fair Poor
 Is your child currently under the care of a physician? Yes No
 Child's Physician : _____
 His / Her phone # : _____
 The approximate date of last visit : _____
 Please rate your child's medical health : Good Fair Poor
 Is your child allergic to latex? Yes No
 Is your child allergic to any drugs or other things? Yes No
 If yes, please list : _____
 Is your child taking any prescription drugs? Yes No
 If yes, please list : _____
 Does your child require antibiotics before dental treatment?
 Yes No

4 If you (parent or legal guardian) will not be present for your child's entire dental appointment...

Dr. Gillis and Dr. Hanson request your permission for any/all of the following dental treatments, if recommended, for your child during their routine dental exams and dental cleaning appointments:

- ___ Bitewing x-rays (for cavity detection) Yes No
- ___ Panoramic x-rays (evaluate wisdom teeth) Yes No
- ___ Fluoride Application (cavity prevention) Yes No
- ___ Sealants _____ Yes No

Parent / Guardian : _____
 Date : _____

The above authorization will remain in place until a written notification of change is received by the Gillis Dental office.

2 Has your child ever had any of the following medical conditions or problems?

- Yes No Any hospital stays
- Yes No Any operations
- Yes No Bleeding problems of any kind
- Yes No Cancer
- Yes No Convulsions / Epilepsy
- Yes No Diabetes
- Yes No Hearing impairment
- Yes No Heart Murmur
- Yes No Heart problems of any kind
- Yes No Hemophilia
- Yes No HIV+ / AIDS
- Yes No Hyperactive
- Yes No Rheumatic/Scarlet fever

3 Are there any other medical problems relating to your child? Yes No

If yes, please explain : _____

This column for office use only:
 Medical History Update

Date: _____ By: _____
 Pre-medication: _____
 Any Changes? _____
 If so, what? _____

Medications? _____
 If so, what? _____

Signature of Parent or Guardian: _____

Date: _____ By: _____
 Pre-medication: _____
 Any Changes? _____
 If so, what? _____

Medications? _____
 If so, what? _____

Signature of Parent or Guardian: _____

Date: _____ By: _____
 Pre-medication: _____
 Any Changes? _____
 If so, what? _____

Medications? _____
 If so, what? _____

Signature of Parent or Guardian: _____

5 In the event of any emergency, who should we contact?

Name : _____ Relationship : _____
 Phone 1 : (_____) _____
 Phone 2 : (_____) _____

6

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I agree to be responsible for payment of all services rendered by this office. Should I have any dental insurance benefits, I further agree to authorize the release of any medical and dental information necessary in order to process any insurance benefits for all professional services rendered. I also authorize the assignment of any insurance benefits to the office of Richard C. Gillis, D.M.D., P.C. I have received a copy of this office's Notice of Privacy Practices. By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

 Signature of Parent or Guardian

Date