



GALLIGAN FAMILY DENTISTRY

Caring for Every Smile, Every Generation

Welcome and thank you for choosing Galligan Family Dentistry. We would like your visit with us to be a pleasant, comfortable, and safe experience. Please help us achieve this goal by providing the following information:

Patient & Parent Information

Child Name: _____
Last First Middle Nickname

Address: _____
Street

_____ City State Zip Code

Child Date of Birth: _____ Child Age: _____ Child School: _____

Parent Employer: _____ Parent Driver's License Number: _____

Parent Soc. Sec. Number: _____ Pediatrician: _____

Phone: Mobile: _____ Email: _____

Home: _____ Work: _____

Emergency Contact: _____
Name Phone Number

Insurance Information

Primary Insurance: _____ Primary Insurance Subscriber Phone: _____

Subscriber Name: _____ Relationship: Self Spouse Dependent Other

Subscriber #/SS#: _____ Employer: _____ Group Number: _____

Do you have other coverage: Flex Spending Account Health Savings Account Secondary Insurance

Other Information

How did you hear about us? Drive-By Mailer Sent to Home At Work School/Preschool

Internet Apartment Office Neighborhood Club/Office Insurance Website Newspaper

Who may we thank for referring you? _____

What are your child's interests or hobbies? _____

Does your child have any special concerns that we need to be aware of? _____

Dental History

What is the primary reason for today's visit? _____

Is there anything specifically we can do to help make your experience with us exceptional?

- Disease Prevention**
- Do other family members have a history of cavities? Yes No
- Does your child use floss or flossers? Yes No
- Does a parent routinely supervise your child's brushing? Yes No
- Is your child a "picky" or "grazing" eater? Yes No
- Habits & Trauma**
- Has your child experienced facial or oral trauma? Yes No
- Does your child chew on ice or other hard foods? Yes No
- Does your child bite fingernails, pens, etc.? Yes No
- Does/did your child suck his/her thumb or fingers? Yes No
- Dental Development**
- Are you concerned about eruption or alignment of your child's teeth? Yes No
- Has your child needed baby teeth professionally removed? Yes No
- Do your child's baby teeth tend to shed: Early Moderate Late
- Has your child begun puberty? Yes No
- Has your child undergone orthodontic treatment? Yes No
- If yes: Phase 1/Interceptive Teen/Comprehensive

Please note anything else that you would like to discuss about your child's oral health, dentition, or development:

Medical History

Please realize that many medications that your child may be using and health conditions he/she may have could make a significant difference in how we treat your child's dental needs. We ask that you assist us in maintaining our effort for optimal and safe dental care by completing the following information as thoroughly as possible. Furthermore, we genuinely care about your child's health and aim to enhance overall well-being. Thank you.

Medications

Please list all prescribed medications as well as over-the-counter medications that your child is routinely taking and reason for their use (please provide a separate list if extensive):

Allergies

Please indicate any drug or material allergies and specify by name (antibiotic, narcotic pain medication, latex, etc.):

General

- Is your child in good health? Yes No
- Has your child been hospitalized in the past 2 years? Reason: _____ Yes No

