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

Developmental

□ Mental Delay: ____________________________

□ Physical Delay: ___________________________

□ Autistic Spectrum Disorder

□ Birth Defect / Genetic Disorder:

____

Cardiovascular

□ Rheumatic Fever

□ Congenital Heart Defect:

____

Hematologic

□ Anemia

□ Hemophilia

□ Blood Thinner: □ Aspirin □ Coumadin □ Plavix □ Other

□ Hepatitis: □ A □ B □ C □ D

Endocrine

□ Currently taking birth control

□ Diabetes: □ Type I □ Type II

□ Thyroidism: □ Hypo □ Hyper

□ Adrenal Disorder

□ Transplant – Organ: ___________ Year: ________

□ Hormone Replacement – Hormone: ____________

Cancer

What Type: _________________________________

Year Diagnosed: ______________________________

Neurologic

□ ADD / ADHD

□ Frequent Headaches

Most common time of day: _________________

Typical trigger: ___________________________

□ Epilepsy/Seizures – Trigger: __________________

□ Psychiatric Disorder – Type: __________________

□ History of Drug or Alcohol Abuse

□ Bulimia or Anorexia

Pulmonary

□ Tuberculosis (TB)

□ Asthma

□ Chronic Bronchitis

Genitourinary

□ Kidney Failure

□ STD – Type: ______________________________

□ HIV/AIDS

Miscellaneous

□ Impaired: □ Vision □ Hearing □ Speech

□ Arthritis: □ Osteo □ Rheumatoid

□ Fever Blisters/Cold Sores

□ TMD

□ Sjogrens Disease

□ Gastric Reflux (GERD)

□ Chronic Dry Mouth (Xerostomia)

□ Other conditions we should be aware of:

____

____

I authorize Dr. Abigail Scanlan and staff to perform radiographs (x-rays), photographs, and/or other routine diagnostic procedures necessary to make a thorough diagnosis of my child's dental needs.

I have received a copy of Galligan Family Dentistry's HIPAA privacy practices.

I acknowledge that the information provided here is as complete as possible and to the best of my knowledge.

___________________________ ___________________________________ __________________

Patient Name Signature (Patient/Legal Guardian) Date