# Gavin P. Lynch D.D.S., P.C.
*General Dentistry*

## We are pleased to welcome you to our practice.

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

## Patient Information

Name of Minor/Child ______________________________________________
Last Name First Name Middle Initial

Sex ☐M ☐F Age________ Birth Date______________ Nickname____________________ Hobbies ______________________

Home Address ______________________________________________
Street City State Zip

Mailing Address ______________________________________________
Street City State Zip

Person financially responsible______________________________ Home Phone_________________ Work Phone____________________

Whom may we thank for referring you? ______________________________________________

## Insurance

Father's/Guardian's Name______________________________________
Address (if different from patient's) ____________________________
______________________________________________
Home Phone________________ Work Phone ____________________
Employer ______________________________________________
SS#________________________ Birth Date ____________________
Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No
Plan Name______________________________________________
Phone #______________________________________________
Address______________________________________________
______________________________________________
Group # ______________________________________________
Policy # ______________________________________________

Mother's/Guardian's Name ______________________________________
Address (if different from patient's) ____________________________
______________________________________________
Home Phone________________ Work Phone ____________________
Employer ______________________________________________
SS#________________________ Birth Date ____________________
Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No
Plan Name______________________________________________
Phone #______________________________________________
Address______________________________________________
______________________________________________
Group # ______________________________________________
Policy # ______________________________________________

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance ID#______________________

## Dental History

Date of last visit to a dentist______________________________ For what service? ______________________________

| | YES | NO |
|---|---|---|
| Has child complained about dental problems? | ☐ | ☐ |
| Does child brush teeth daily? | ☐ | ☐ |
| Does child use floss every day? | ☐ | ☐ |
| Is fluoride taken in any form? | ☐ | ☐ |
| Any injuries to mouth, teeth, head? | ☐ | ☐ |
| Any unhappy dental experiences? | ☐ | ☐ |
| Any mouth habits — thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle? | ☐ | ☐ |

***Please Complete Both Sides***

## Medical History

Minor/Child's Physician_______________________ City/State_____________ Phone_____________________

Date of last physical examination_______________________ Results _______________________________

| | YES | NO |
|---|---|---|
| Is minor/child under care of a physician now? | ☐ | ☐ |
| Receiving any medications or drugs? | ☐ | ☐ |
| Ever been hospitalized? | ☐ | ☐ |
| Ever had surgery? | ☐ | ☐ |
| Is there excessive bleeding when cut? | ☐ | ☐ |

Medications _______________________________________________

Allergies _______________________________________________

Has minor/child had any history of or difficulty with any of the following? If yes, please check the box.

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Cerebral Palsy | ☐ Epilepsy | ☐ Kidney Disease | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Chicken Pox | ☐ Fainting | ☐ Liver Disease | ☐ Sinus Problems |
| ☐ Asthma | ☐ Convulsions | ☐ Hearing Problems | ☐ Measles | ☐ Thyroid Disease |
| ☐ Bladder Problems | ☐ Diabetes | ☐ Heart Problems | ☐ Mononucleosis | ☐ Tuberculosis |
| ☐ Cancer | ☐ Drug/Alcohol Abuse | ☐ Hepatitis | ☐ Mumps | ☐ Other |

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

Name_________________________ Relationship_________________ Phone_________________

Name_________________________ Relationship_________________ Phone_________________

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my doctor if my minor/child ever has a change in health.

**Minor/Child Consent**

I am the parent, guardian, or personal representative of _______________________________________________
Please print name of minor/child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

**Insurance Assignment and Release**

I certify that my dependent(s) is covered by insurance with ___________________________________ and assign directly to

Dr. ___________________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from date signed below.

_______________________________________________ _________________
Signature of Parent, Guardian or Personal Representative | Date

_______________________________________________ _________________
Please print name of Parent, Guardian or Personal Representative | Relationship to Patient

### TO BE COMPLETED AT A LATER VISIT

Has there been any change in patient's health since last visit? ☐ Yes ☐ No

If yes, please describe_______________________________________________

Is patient taking any new medications? ☐ Yes ☐ No

If yes, please list_______________________________________________

_______________________________________________ _________________
Signature of Parent, Guardian or Personal Representative | Date

_______________________________________________ _________________
Dentist Signature | Date