Welcome

The Groovy Molar Team is pleased to welcome you and your child to our practice! In an effort to provide optimal treatment for your child, please complete the following form.

Tell Us About Your Child

Today's Date:	Child's Full Name:	
Preferred Name:	Male ☐ Female ☐ Age:	Date of Birth: / /
SSN:	School:	Home Ph#:
Home Address:		

Other siblings seen in office: _____

Is there someone we may thank for referring you? Friend ☐ Pediatrician ☐ Dentist ☐
Please list name/other:

Person Responsible

Name:	Relation:	SSN:
Phone#:	Employer:	

Parent's Information

Parent's Marital Status: Married ☐ Divorced ☐ Separated ☐ Widowed ☐
Remarried ☐ Single ☐

Mother's Name:		Date of Birth:
Address (if different than child):		
Employer:	SSN:	Email Address:
Home Ph#:		Work Ph#:
Cell Ph#:		

Groovy Molar
Pediatric Dental Care

Parent's Information

Father's Name:		Date of Birth:
Address (if different than child):		
Employer:	SSN:	Email Address:
Home Ph# (if different):		Work Ph#:
Cell Ph#:		

Dental Insurance

Primary Insurance:	Insurance Phone #:
Policy Holder's Name:	Policy Holder's DOB:
Group/Policy #:	Employer:
SSN:	

Secondary Insurance:	Insurance Phone #:	Employer:
Policy Holder's Name:	Group/Policy #:	SSN:

Medical History

Child's Physician:	Phone #:	Treatment in Progress: Y ☐ N ☐ Condition:
Specialists, please list:		Allergies (seasonal, food, drug):
Medications (w/ reason taken):		

Medical History

- ☐ Abnormal Bleeding
- ☐ ADD ☐ ADHD
- ☐ AIDS/HIV+
- ☐ Allergies (antibiotic, food, metals)

_____

- ☐ Allergic to Latex
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma ☐ Mild ☐ Mod ☐ Sev
- ☐ Autism Spectrum
- ☐ Birth: gestational age ____weeks
- ☐ Blood Transfusion
- ☐ Brain Injury
- ☐ Bruise/ Bleeds Easily
- ☐ Cancer
- ☐ Chemotherapy or Steroid Therapy
- ☐ Cerebral Palsy
- ☐ Congenital Heart Defect
- ☐ Cleft lip and/or palate
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Emotional/ Psychiatric Issues
- ☐ Epilepsy
- ☐ GERD (Reflux)
- ☐ Hearing Impairment
- ☐ Heart Murmer ☐ Innocent
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High ☐ Low Blood Pressure
- ☐ Hives
- ☐ Joint Replacement
  Date (month/yr):
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Problems
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sensory Integration
- ☐ Shunt
- ☐ Sickle Cell Anemia
- ☐ Thyroid
- ☐ Tonsils (Snores)
- ☐ Tuberculosis
- ☐ Visual Impairment

Please list and/ or explain surgeries, complications, conditions, syndromes not listed:

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. Personal information will be held in the strictest confidence, and I understand it is my responsibility to inform Groovy Molar, PLLC of any changes in my child's medical status.

I authorize the necessary release of any dental records to my insurance company and/or health care practitioners.

I give consent for Groovy Molar, PLLC to perform the necessary dental services my child may need, including any diagnostic radiographs needed.

_____ Signature Parent/Guardian/ Date

I understand that I am responsible for any fees related to dental services in full. Groovy Molar, PLLC as a courtesy will file any and all dental insurances. I understand I will be directly reimbursed by my dental insurance company.

_____ Signature Parent/Guardian/ Date

Thank You for your time,

Team Groovy Molar