NEW PATIENT FORM

Today's Date: ___________

TELL US ABOUT YOUR CHILD

Child's Name: ______________________________________
Last First Middle

Goes By: ______________________ ☐ Male ☐ Female

Siblings that we treat: ___________________________

Child's Birthdate: _____ /_____ /_____ Child's Age _____

PRIMARY CONTACT GUARDIAN INFO

Relationship ☐ Mother ☐ Father ☐ Other__________

Birthdate: _____ / _____ /_____ SSN: __________

Employer: ___________________________________

Cell #: (___)__________ Work #: (___)__________

Email: ______________________________________

Address: ____________________________________

____

SECONDARY CONTACT GUARDIAN INFO

Relationship ☐ Mother ☐ Father ☐ Other__________

Birthdate: _____ / _____ /_____ SSN: __________

Employer: ___________________________________

Cell #: (___)__________ Work #: (___)__________

PARENTAL MARITAL STATUS

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

HOW DID YOU HEAR ABOUT US?

Name/Source: ________________________________

Which gift card would you like if referring a patient to us?
☐ Starbucks ☐ Amazon

PRIMARY DENTAL INSURANCE

Primary Subscriber: ___________________________

Subscriber Birthdate: ____ /____ / ____ SSN: ________

Relationship to the Patient: _____________________

Employer: ___________________________________

Insurance Company: ___________________________

Insurance Co. Phone #: (______) ________________

ID # ____

Group # _____________________________________

SECONDARY DENTAL INSURANCE

Primary Subscriber: ___________________________

Subscriber Birthdate: ____ /____ / ____ SSN: ________

Relationship to the Patient: _____________________

Employer: ___________________________________

Insurance Company: ___________________________

Insurance Co. Phone #: (______) ________________

ID # ____

Group # _____________________________________

CONSENT FOR DENTAL TREATMENT

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

I authorize the dental staff to perform the necessary dental services my child may need

I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents

Signature ____________________________ Date ______

MEDICAL HISTORY

Child's Physician: ______________________________

Child's Physician Ph #: (_____) ______________________

Preferred Pharmacy: ______________________

Pharmacy #: (____) ______________________________

PLEASE INDICATE IF YOUR CHILD HAS A HISTORY OF:

Y	N	Adopted/Foster Child	Y	N	Gastrointestinal Disorder
Y	N	Anemia	Y	N	Heart Disease
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	Asthma/Reactive Airway	Y	N	HIV/AIDS
Y	N	Autism/PDD	Y	N	Kidney Disorder
Y	N	Bleeding/ Transfusions	Y	N	Liver Disorder
Y	N	Cancer/Tumors	Y	N	Mental/Physical Handicap
Y	N	Cerebral Palsy	Y	N	Pregnancy
Y	N	Cleft Lip/Palate	Y	N	Premature
Y	N	Congenital Birth Defect	Y	N	Rheumatic Fever
Y	N	Diabetes	Y	N	Seizure/Epilepsy
Y	N	Down Syndrome	Y	N	Speech/Hearing
Y	N	Ear Infection/Tubes	Y	N	Sleep Apnea/Snoring
Y	N	Eyes/Vision	Y	N	Tuberculosis

Please describe any medical problems that your child has: ______________________________

____

____

Has your child ever been hospitalized or had any surgical procedures? ☐ Y ☐ N

Please list reasons and dates ______________________________

____

____

Does your child have any allergies to food or medications? ☐ Y ☐ N

Please list ______________________________

____

Is your child taking any medications? ☐ Y ☐ N

Please list ______________________________

____

____

Is your child up-to-date on vaccinations? ☐ Y ☐ N

Does your child see any specialists? ☐ Y ☐ N

Please list ______________________________

____

____

DENTAL HISTORY

Is this your child's first visit to the dentist? ☐ Y ☐ N

If not, how long since the last visit to the dentist? __________

Previous dentist's name: ______________________________

Were any x-rays taken at previous dental visits? __________

Has your child had an unfavorable experience in a previous medical or dental office? If yes, please describe __________

____

Reason for changing dentists? ______________________________

Have there been any injuries to the teeth, face or mouth?

If yes, please describe______________________________

____

Why did you bring your child to the dentist today? ________

____

Has an Orthodontist seen your child? If so, who? __________

____

Who performs brushing and flossing ? ☐ Parent ☐ Child

Does your child brush daily? ☐ Y ☐ N

Does your child floss daily? ☐ Y ☐ N

Does your child receive fluoride in:

☐ Toothpaste ☐ Water ☐ Supplements ☐ None

Has your child ever had pain in his/her jaw? ☐ Y ☐ N

PAST AND CURRENT HABITS

			Age stopped
Breast fed	☐ Y	☐ N	________
Bottle fed	☐ Y	☐ N	________
Went to bed with bottle of milk	☐ Y	☐ N	________
Feedings after night brushing	☐ Y	☐ N	________
Pacifier	☐ Y	☐ N	________
Thumb/Finger Habit	☐ Y	☐ N	________
Grazing/Frequent Snacking			☐ Y ☐ N
Drinking sugar containing drinks between meals			☐ Y ☐ N

DENTAL CONCERNS

Does your child have problems with any of the following:

Cavities	☐ Y	☐ N
Teeth or fillings breaking	☐ Y	☐ N
Crowding/Bite Issues	☐ Y	☐ N
Toothache/Pain	☐ Y	☐ N
Color of teeth	☐ Y	☐ N
Sensitive teeth	☐ Y	☐ N
Bleeding, swollen or irritated gums	☐ Y	☐ N