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 ______

Parental Marital Status

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

PRIMARY CONTACT GUARDIAN INFO

Name: ______________________________

Relationship ☐ Mother ☐ Father ☐ Other__________

Birthdate: ______ / ______ /______ SSN: __________

Occupation: ______________________________

Cell #: (____)__________ Work #: (____)__________

Email: ______________________________

Address: ______________________________

____

SECONDARY CONTACT GUARDIAN INFO

Name: ______________________________

Relationship ☐ Mother ☐ Father ☐ Other__________

Birthdate: ______ / ______ /______ SSN: __________

Occupation: ______________________________

Cell #: (____)__________ Work #: (____)__________

Address: ______________________________

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

How often does your child brush per day? ___________

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