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 may 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

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