

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 □	l Widowed □ Single
PRIMARY CONTACT	' GUARDI	AN INFO
Name:		
Relationship \square Mother \square	Father \square 0	ther
Birthdate: / /	SSN	Ī:
Occupation:		
Cell #: ()	_Work #: (_)
Email:		
Address:		
SECONDARY CONTA	ACT GUAI	RDIAN INFO
Name:		
Relationship \square Mother \square	Father \square 0	ther
Birthdate: / /	SSN	I:
Occupation:		
Cell #: ()	_Work #: (_)
Address:		
HOW DID YOU HEAD	R ABOUT	US?
Name/Source:		
Which gift card would you li ☐ Starbucks		

NEW PATIENT FORM

Today's Date: _____

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

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	Data
Signature	Date

MEDICAL HISTORY

Child's Physician Ph #: (_)				
Preferred Pharmacy:	-				
Pharmacy #: ()					
PLEASE INDICATE IF YOUR O	CHII	.D 1	HAS A HISTO	RY OI	?:
1 /	Y	N	Gastrointesti	inal D	isorder
N Anemia			Heart Diseas	e	
N ADD/ADHD			Hepatitis		
N Asthma/Reactive Airway			•	,	
N Autism/PDD			Kidney Disor		
N Bleeding/ Transfusions			Liver Disord		
N Cancer/Tumors N Cerebral Palsy			Mental/Phys Pregnancy	icai H	ianuicaț
N Cleft Lip/Palate			Premature		
N Congenital Birth Defect			Rheumatic F	ever	
N Diabetes			Seizure/Epil		
N Down Syndrome			Speech/Hear	_	
N Ear Infection/Tubes					ing
					Ü
Please describe any medical has:	pro	obl		r chil	
has:Has your child ever been ho	pro	obl	ems that you	r chil	gical
Please describe any medical has:	pro	obl	ems that you	r chil	
Please describe any medical has: Has your child ever been hoprocedures?	pro	obl	ems that you	r chil	gical
Please describe any medical has: Has your child ever been hoprocedures?	pro	ali	ems that you	r chil	gical
Please describe any medical has: Has your child ever been hoprocedures? Please list reasons and dates	pro	ali	zed or had an	ny sui	gical
Please describe any medical has: Has your child ever been hoprocedures? Please list reasons and dates Does your child have any all	pro-	ali	zed or had an	ny sui	gical
Please describe any medical has: Has your child ever been hoprocedures? Please list reasons and dates Does your child have any all medications? Please list	spit	ies	zed or had an	ny sui	gical
Please describe any medical has: Has your child ever been hoprocedures? Please list reasons and dates Does your child have any all medications? Please list Is your child taking any medical have any medical has been hopping and have any all have any all have any medical has been hopping and have any all	spit	ies	zed or had an	ny sui	rgical N N
Please describe any medical has: Has your child ever been hoprocedures? Please list reasons and dates Does your child have any all medications? Please list	spit	ies	zed or had an	ny sui	rgical N N
Please describe any medical has: Has your child ever been hoprocedures? Please list reasons and dates Does your child have any all medications? Please list Is your child taking any medical have any medical has been hopping and have any all have any all have any medical has been hopping and have any all	erg	ies	zed or had an	ny sui	rgical N N
Please describe any medical has: Has your child ever been hop procedures? Please list reasons and dates Does your child have any all medications? Please list Is your child taking any medicates list	spit	ies	zed or had and to food or	ny sur	□ N

DENTAL HISTORY

Is this your child's first 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 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 N Seedings after night brushing Y N N Feedings after night brushing Y N N Pacifier Y N N Freedings after night brushing Y N N Pacifier Y N N Dentral CONCERNS Does your child have problems with any of the following: Cavities Y N N Teeth or fillings breaking Y N N Crowding/Bite Issues Y N N Color of teeth Y N N Sensitive teeth Y N N Sensitive teeth Y N N Color of feeth Y N N Sensitive teeth Y N N Color of sensitive teeth Y N N Sensitive teeth Y N N Color of teeth Senses Y N N Color of teeth Senses Y N Color of teeth S								
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	Previous dentist's name:							
Reason for changing dentists?	Were any x-rays taken at previous dental visits?							
Reason for changing dentists?	Has your child had an unfavorable experience in a	previous						
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 N N Bottle fed Y N N N Feedings after night brushing Y N N Pacifier Y N N Carzing/Frequent Snacking Y N N DENTAL CONCERNS Does your child have problems with any of the following: Cavities Y N N Teeth or fillings breaking Y N N Crowding/Bite Issues Y N N Color of teeth Y N N Sensitive teeth Y N N Color of teeth Y N N Color of teeth Y N N And The today of the following: Cavitive Y N N Color of teeth Y N Color of teeth								
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:	Reason for changing dentists?							
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Has an Orthodontist seen your child? If so, who? Who performs brushing and flossing? Parent								
Who performs brushing and flossing? Parent Child How often does your child brush per day? Y N N Does your child floss daily? Y N 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 N	Why did you bring your child to the dentist too	lay?						
How often does your child brush per day? Does your child floss daily? 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 N N Bottle fed Y N N N Went to bed with bottle of milk Y N N Feedings after night brushing Y N N N Feedings after habit Y N N N Grazing/Frequent Snacking Y N N DENTAL CONCERNS Does your child have problems with any of the following: Cavities Y N N Toothache/Pain Y N N Color of teeth Y N N Constitive teeth Y N Constitive teeth	Has an Orthodontist seen your child? If so, who	9?						
Does your child floss daily? 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 N Bottle fed Y N N Feedings after night brushing Y N N Feedings after night brushing Y N N Frazing/Frequent Snacking Y N N Grazing/Frequent Snacking Y N DENTAL CONCERNS Does your child have problems with any of the following: Cavities Y N Teeth or fillings breaking Y N Toothache/Pain Y N Color of teeth Y N Constitive teeth Y N	Who performs brushing and flossing ? □ Pare	nt 🗆 Child						
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 N Seedings after night brushing Y N Feedings after night brushing Y N Frequent Snacking Y N DENTAL CONCERNS Does your child have problems with any of the following: Cavities Y N Toothache/Pain Color of teeth Sensitive teeth	How often does your child brush per day?							
Toothpaste Water Supplements None Has your child ever had pain in his/her jaw?	Does your child floss daily?	\square Y \square N						
PAST AND CURRENT HABITS Age stopped Breast fed		□ None						
Breast fed	Has your child ever had pain in his/her jaw?	\square Y \square N						
Breast fed	PAST AND CURRENT HABITS							
Bottle fed		Age stopped						
Went to bed with bottle of milk	Breast fed \square Y \square N							
Feedings after night brushing	Bottle fed \square Y \square N							
Pacifier	Went to bed with bottle of milk \Box Y \Box N							
Thumb/Finger Habit								
Grazing/Frequent Snacking								
Drinking sugar containing drinks between meals	, -							
DENTAL CONCERNS Does your child have problems with any of the following: Cavities								
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								
Cavities	DENTAL CONCERNS							
Cavities	Does your child have problems with any of the	following:						
	Cavities	\square Y \square N						
	Teeth or fillings breaking	\square Y \square N						
Color of teeth		\square Y \square N						
Sensitive teeth $\hfill\Box$ Y $\hfill\Box$ N	•							
Rigading ewollon or irritated gime	Sensitive teeth Bleeding, swollen or irritated gums	$\square Y \square N$						