New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 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: ______

School: ______________

Child's Home Address: ______________

____
City State Zip

2 PARENT/LEGAL GUARDIAN #1

Name: ______________

Relationship: ______________ DOB: ____/____/____

Address: ______________

____
City State Zip

Occupaton: ______________

Employer: ______________

Work #: (____)______________

Home #: (____)______________

Cell #: (____)______________

SSN: ______________ DL#: ______________

Email Address: ______________

3 PARENT/LEGAL GUARDIAN #2

Name: ______________

Relationship: ______________ DOB: ____/____/____

Address: ______________

____
City State Zip

Occupaton: ______________

Employer: ______________

Work #: (____)______________

Home #: (____)______________

Cell #: (____)______________

SSN: ______________ DL#: ______________

Email Address: ______________

Parents Marital Status (circle one):

Single Married Divorced Widowed Separated

4 WHO MAY WE THANK FOR REFERRING YOU? (PLEASE SPECIFY)

1) Friend/Word of Mouth (name): ______________

2) Sibling: ______________ 3) Doctor: ______________

4) Internet: ______________ 5) Insurance: ______________

6) Saw Sign Outside: ______________ 7) Other: ______________

5 PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________

Relationship: ______________

6 PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________

Insurance Co. Address: ______________

____
City State Zip

Insurance Phone #: (____) ______________

Group # (Plan, Local, or Policy #): ______________

Policy Owner's Name: ______________

Relationship to Patient: ______________

Policy Owner's Birthdate: ____/____/____

SSN: ______________

Policy Owner's Employer: ______________

7 SECONDARY DENTAL INSURANCE

Insurance Co. Name: ______________

Insurance Co. Address: ______________

____
City State Zip

Insurance Phone #: (____) ______________

Group # (Plan, Local, or Policy #): ______________

Policy Owner's Name: ______________

Relationship to Patient: ______________

Policy Owner's Birthdate: ____/____/____

SSN: ______________

Policy Owner's Employer: ______________

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9 DENTAL HISTORY

Is this your child's first visit to the dentist? ______________

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

Previous dentist's name: ______________

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

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

If yes, please explain: ______________

____

____

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

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing / Bottle Habits
Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: ______________

____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his/her teeth daily? YES NO

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Autism/PDD
Y N ADD/ADHD
Y N Anxiety
Y N Diabetes/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Hemophilia/Blood Disorders
Y N Reflux/GI Problems
Y N Developmental Delay

Please explain any medical conditions that your child has:

____

____

Current medications: ______________

____

Allergies: ______________

____

Child's Pediatrician: ______________

Phone #: (____) ______________

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:

GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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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.

______________ ______________

Signature of Parent or Guardian Date Relationship to Patient

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials ______________ Date ______________

Doctor's Comments ______________

____

____

____

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