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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 #: (____) _____
 SSN: _____
 Child's Home Address: _____

City State Zip

2 MOTHER'S INFORMATION

Name: _____
 Mother Stepmother Guardian Birthdate: ____/____/____
 Address: _____

City State Zip
 Employer: _____
 Work #: (____) _____
 Home #: (____) _____
 Cell #: (____) _____
 SSN: _____ DL#: _____
 Email Address: _____

3 FATHER'S INFORMATION

Name: _____
 Father Stepfather Guardian Birthdate: ____/____/____
 Address: _____

City State Zip
 Employer: _____
 Work #: (____) _____
 Home #: (____) _____
 Cell #: (____) _____
 SSN: _____ DL#: _____
 Email Address: _____

4 WHO MAY WE THANK FOR REFERRING YOU?

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____
 Relationship: _____
 Do you have legal custody of this child? YES NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
 Relationship: _____
 Billing Address: _____

City State Zip
 Work #: (____) _____
 Home #: (____) _____
 Cell #: (____) _____
 Email Address: _____

7 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: _____

8 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: _____

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

11 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 _____

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

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

Please discuss any serious medical conditions the child has had:

Please list all the drugs the child is currently taking: _____

Please list all drugs the child is allergic to: _____

Child's Physician: _____

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.