

# New Patient Form



Today's Date: \_\_\_\_\_

## 1 TELL US ABOUT YOUR CHILD

Child's Name: \_\_\_\_\_

Nickname: \_\_\_\_\_  Male  Female

Child's Birthdate: \_\_\_\_\_ Child's Age: \_\_\_\_\_

School: \_\_\_\_\_

Siblings We Treat: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child's Home #: \_\_\_\_\_

Special Interests: \_\_\_\_\_

## 2 DENTAL HISTORY

Is this your child's first visit to the dentist?  Yes  No

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

Previous Dentist's Name: \_\_\_\_\_

Date of Last X-Rays at Previous Dental Visits: \_\_\_\_\_

Have there been any injuries to the teeth, face or mouth?  Yes  No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Why did you bring your child to the dentist today?

\_\_\_\_\_  
\_\_\_\_\_

Does your child have any of the following habits?

- |  |   |
|--|---|
| <input type="checkbox"/> Lip Sucking / Biting    | <input type="checkbox"/> Nail Biting            |
| <input type="checkbox"/> Nursing / Bottle Habits | <input type="checkbox"/> Thumb / Finger Sucking |
| <input type="checkbox"/> Tobacco Use             |   |

Does your child have any current dental issues?

- |  |  |
|--|--|
| <input type="checkbox"/> Cavities                  | <input type="checkbox"/> Toothache               |
| <input type="checkbox"/> Bleeding Gums             | <input type="checkbox"/> Discolored Teeth        |
| <input type="checkbox"/> Bad Breath                | <input type="checkbox"/> Teeth Grinding          |
| <input type="checkbox"/> Mouth Trauma/Broken Tooth | <input type="checkbox"/> Sensitivity to Hot/Cold |

Has your child ever had a serious or difficult problem associated with previous dental work?  Yes  No

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Is your child's water fluoridated?  Yes  No

Is your child taking fluoride supplements?  Yes  No

Has your child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)?  Yes  No

Does your child brush his/her teeth daily?  Yes  No

Does your child floss his/her teeth daily?  Yes  No

## 3 SOCIAL HISTORY

Child's First Language: \_\_\_\_\_

Child's Second Language: \_\_\_\_\_

## 4 HEALTH HISTORY

Has your child ever had any of the following conditions?

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding           | <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> ADD/ADHD                    | <input type="checkbox"/> Autism Spectrum Disorder          | <input type="checkbox"/> Hearing Impairment         | <input type="checkbox"/> Reflux/GI Problems      |
| <input type="checkbox"/> Allergies to Any Drugs      | <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Hemophilia/Blood Disorders | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Allergies to Latex Products | <input type="checkbox"/> Cardiac (Heart Conditions)        | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Any Hospital Stays          | <input type="checkbox"/> Congenital Birth Defects          | <input type="checkbox"/> HIV + / AIDS               | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Any Operations              | <input type="checkbox"/> Developmental Delays/Disabilities | <input type="checkbox"/> Kidney/Liver Conditions    | <input type="checkbox"/> None of the Above       |

If you checked any of the above conditions, or if you would like to discuss any other medical conditions your child has had, do so below:

\_\_\_\_\_  
\_\_\_\_\_

List all drugs your child is currently taking.

\_\_\_\_\_

List all allergies your child currently has.

\_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Is your child currently under the care of a physician?  Yes  No

Please describe your child's current physical health:

Good  Fair  Poor

## 5 PARENT OR LEGAL GUARDIAN'S INFORMATION

*The information in this section applies to the main legal caregiver of the child / children.*

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Marital Status:

Single  Married  Divorced  Widowed

Address: \_\_\_\_\_

City State Zip

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

SSN: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_

## 6 SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION

*(If different from #2 above.)*

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Marital Status:

Single  Married  Divorced  Widowed

Address: \_\_\_\_\_

City State Zip

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

SSN: \_\_\_\_\_ DL#: \_\_\_\_\_

Email Address: \_\_\_\_\_

## 7 HOW DID YOU LEARN ABOUT OUR PRACTICE

\_\_\_\_\_

## 8 WHO WILL BE ACCOMPANYING THE CHILD/CHILDREN TO THEIR APPOINTMENT?

*Important Note: The parent or guardian who accompanies the child is legally responsible for payment at the time of service.*

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Do you have legal custody of this child?  Yes  No

## 9 PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip

Work #: \_\_\_\_\_

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Email Address: \_\_\_\_\_

## 10 PRIMARY DENTAL INSURANCE

Insurance Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City State Zip

Insurance Phone: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Birthdate: \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

## 11 DUAL (SECONDARY) INSURANCE

Do you have dual (secondary) insurance?

Yes  No

Insurance Name: \_\_\_\_\_

## 12 SIGNATURE

**I understand that the information I have given is correct to the best of my knowledge and that 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

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

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

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_