

New Patient Form

Today's Date: _____



My First Dentist
pediatric dentistry

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 _____