New Patient Form (1 of 3)

Child's Information

Last Name_____First_____Middle_____

Preferred Name_____Date of Birth _____Age_____Sex ☐M ☐F

Does patient attend school? ☐Yes ☐No If yes, where?_____Grade_____

Parent/Guardian Information

Mother's Full Name_____Date of Birth_____

Address_____

Home #_____Cell #_____Work #_____

Employer_____

Email _____

If the above information is not for the mother, what is relationship to child?_____

Father's Full Name_____Date of Birth_____

Address_____

Home #_____Cell #_____Work #_____

Employer_____

Email _____

If the above information is not for the father, what is relationship to child?

Who does the child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____

How did you hear about us?_____

Insurance Information

Insurance Carrier_____Policy #_____

Policy Owner's Name_____Relationship_____

Policy Owner's Employer_____

Emergency Contact Information

Name (other than spouse):_____Relationship to Child_____

Home #_____Cell #_____Work #_____

New Patient Form (2 of 3)

Health History

Child's Physician_____Phone #_____

Date of last physical exam_____Results_____

Circle Yes or No

1. Is your child under the care of a physician (other than routine care)? YES NO
   Name of Dr._____
2. Does your child take ANY medications or supplements? YES NO
   List:_____
3. Has your child ever been hospitalized? YES NO
   Details:_____
4. Has your child ever had surgery? YES NO
   Details:_____
5. Is there anything artificial placed in your child's body (pins, shunts, rods, etc.) YES NO
   Details:_____
6. Does your child have any allergies (ie. penicillin, latex, nuts, etc.)? YES NO
   List:_____
7. Are there any physical or mental problems? YES NO
   List:_____
8. Are there any learning difficulties? YES NO
   Details:_____
9. Were there any problems at or before birth? YES NO
   Details:_____
10. Does your child have bleeding disorders? YES NO

HAS YOUR CHILD HAD ANY HISTORY OF, OR DIFFICULTY WITH ANY OF THE FOLLOWING: Circle

Anemia	Diabetes	Hepatitis	Rheumatic Fever
Asthma	Epilepsy	HIV	Sickle Cell
Cerebral Palsy	Frequent Infections	Kidney	Thyroid
Chronic Sinus	Hearing	Liver	Tuberculosis
Convulsions	Heart/Heart Murmur	Malignancies	Other

Please describe any other medical concerns, surgeries, injuries, etc., or any other information we should be aware of:_____

_____

_____

May we request release of your child's medical records for our reference? YES NO

New Patient Form (3 of 3)

Dental History

Date of patient's last dental visit_____Name of Dentist_____

What was done?_____Were x-rays taken? ☐Yes ☐No

Has patient had any unhappy dental experiences? ☐Yes ☐No

If yes, please explain_____

Does the patient have a toothache? ☐Yes ☐No

At what age did patient discontinue the bottle or nursing? _____ years _____ months

Does patient have any mouth habits (thumb/finger sucking, pacifier, grinding, etc) ☐Yes ☐No

If yes, please explain_____

Does patient have any TMJ/Jaw pain? ☐Yes ☐No

Has patient had any injuries to the mouth, teeth or head? ☐Yes ☐No

If yes, please explain_____

Does patient brush daily? ☐Yes ☐No (If yes, how many times? _____)

Does patient use floss? ☐Yes ☐No

Does an adult assist the patient with the above? ☐Yes ☐No (If yes, who? _____)

Is your child, or has your child, ever taken fluoride supplements? ☐Yes ☐No

If there is additional information that you feel might be of value to us, please comment_____

_____

_____

Consent for Treatment of a Minor

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Dentist may deem necessary during performance of any procedure or treatment.

I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Dentist.

Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.

Signature_____Date_____

Print Name_____Relationship to patient_____