New Patient Form

Today's Date:

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Board Certified Pediatric 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?

- ☐ Lip Sucking / Biting
- ☐ Nail Biting
- ☐ Nursing / Bottle Habits
- ☐ Thumb / Finger Sucking
- ☐ Tobacco Use

Does your child have any current dental issues?

- ☐ Cavities
- ☐ Toothache
- ☐ Bleeding Gums
- ☐ Discolored Teeth
- ☐ Bad Breath
- ☐ Teeth Grinding
- ☐ Mouth Trauma/Broken Tooth
- ☐ 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?

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

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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 MOTHER'S INFORMATION

Name: ______________________________

Relationship: ______________ Birthdate: ______________

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: ______________________________

____
City State Zip

Employer: ______________________________

Work #: ______________________________

Home #: ______________________________

Cell #: ______________________________

SSN: ______________ DL#: ______________

Email Address: ______________________________

6 FATHER'S INFORMATION

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: ______________________________

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11 DUAL (SECONDARY) INSURANCE

Do you have dual (secondary) insurance? ☐ Yes ☐ No Insurance Name: ______________________

12 SIGNATURE

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

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.

Initials ______________ Date ______________

Doctor's Comments ______________________

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