

NEW PATIENT FORM

About Your Child

Child's Name _____

Name Child Prefers To Be Called _____

Age _____ Gender _____ Date of Birth _____

Address _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____ Patient's School District (county/city) _____

Grade Level _____ Patient's Hobbies/Pets _____

Other Children and Their Ages _____

Referred To Our Office By (We Wish To Thank Them) _____

Parent's Marital Status:

Married Divorced Separated Widowed Single

Dental History

Yes No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child? _____

Yes No Do you expect your child to be a cooperative patient? If no, please explain. _____

Yes No Do you have well water at home?

Yes No Does your child take fluoride tablets or vitamins with fluoride?

Yes No Has your child bumped any teeth? If so, when? _____

Yes No Has your child had a history of headaches, pain, popping or clicking of the jaws?

Yes No Does your child still have a night time bottle?

Yes No Does your child have a toothache?

Does your child have or has he or she had any of the following problems or habits?

Thumb Sucking How Long? _____ Still Active Yes No

Finger Habit How Long? _____ Still Active Yes No

Pacifier How Long? _____ Still Active Yes No

Medical History

Is your child presently under the care of your family physician for any medical reason? Yes No If yes, explain _____

Family Physician's Name: _____

Address: _____

Phone Number: _____

• Is your child in good health? If no, explain _____ Yes No

• Is your child under the care of a physician for other than routine care? If yes, explain _____ Yes No

• Does your child have any drug allergies? If yes, explain _____ Yes No

• Is your child taking any medications at this time? If yes, list. _____ Yes No

• Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? _____ Yes No

• Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. _____ Yes No

• Have your child's tonsils and/or adenoids been removed? Yes No

• Does your child breathe through the mouth? If yes, Seldom Often Yes No

Please indicate if your child has had any of the following:

Allergy to Penicillin

Intellectual disability

Anemia

Latex allergy/sensitivity

Asthma

Liver problems or hepatitis

Autism/Asperger's Syndrome

Malignancies or leukemia

Bleeding disorder

Other drug allergy

Bone disorder

Physical handicap

Cleft palate

Positive for H.I.V.

Diabetes

Radiation treatment

Endocrine disorder

Rheumatic fever

Epilepsy, seizures

Speech problem

Hyperactivity/ADD/ADHD

Tuberculosis

Heart ailment or murmur. Type, if known _____

Is child under the care of a cardiologist or special physician for the problem? If so, whom _____

Phone _____

Please comment on any problems that were checked in the above areas _____

Do you consider your child to be:

• Advanced in the learning process Yes No

• Progressing normally Yes No

• A slow learner Yes No

Dental History

How often does your child brush? _____

Is toothbrushing supervised? Yes No

By whom? _____

Is dental floss used? Yes No

Does your child receive: Fluoride in vitamins

Fluoride tablets/drops Bottled water

Fluoridated water Well water

Nearest Relative/Friend

Name _____

Address _____

Apt _____

City _____

State _____

Zip _____

Phone _____

Relationship _____

In case you are not at home, what is your neighbor's

Name _____

Phone _____

Responsible Party

Father's Full Name

Address _____

Apt _____

City _____

State _____

Zip _____

SS# _____

Birthdate _____

Home Phone _____

Cell Phone _____

Business Phone _____

Employer _____

Occupation _____

Email Address _____

Dental Insurance: Yes No

Insurance Company _____

Group or Plan Number _____

Insurance Company Phone _____

Mother's Full Name

Address _____

Apt _____

City _____

State _____

Zip _____

SS# _____

Birthdate _____

Home Phone _____

Cell Phone _____

Business Phone _____

Employer _____

Occupation _____

Email Address _____

Dental Insurance: Yes No

Insurance Company _____

Group or Plan Number _____

Insurance Company Phone _____

Financial Information

Method of Payment:

Please check one:

Check or cash at time of treatment

Visa, Mastercard, American Express or Discover

Insurance form with co-payment at time of treatment

Other: _____

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment.
- Patients with insurance plans we participate with may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to my dental office, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNED (Guarantor)

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED (parent or legal guardian)

DATE