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New Patient Form

Today's Date: ___ /___ /______

TELL US ABOUT YOUR CHILD

Child's Name: ______________________________________

Goes by: _________________ Birth Sex: ☐ Male ☐ Female

Current Gender Identity: ___________________________

Child's Birthdate: ____ /____ /_______ Child's Age: ________

Child's Home #: (______) ___________________________

SSN: ____

Child's Home Address: ______________________________

____

GUARDIAN-1 INFORMATION

Name: ____

Relation to patient: _______________DOB: ___ /___ /______

Address: ____

____

Employer: ____

Work #: (______)____________________________________

Home #: (______)___________________________________

Cell #: (______)_____________________________________

SSN: _______________ DL#: __________________________

Email: ____

GUARDIAN-2 INFORMATION

Name: ____

Relation to patient: _______________DOB: ___ /___ /______

Address: ____

____

Employer: ____

Work #: (______)____________________________________

Home #: (______)___________________________________

Cell #: (______)_____________________________________

SSN: _______________ DL#: __________________________

Email: ____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Guardian-1 & 2 ☐ Guardian-1 ☐ Guardian-2

☐ Other: ____

WHO DOES THE PATIENT LIVE WITH?

Name: ____

Relation: ☐ Biological ☐ Adopted ☐ Foster

☐ Nanny ☐ Other: _________________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____

Relation to patient: ________________________________

Billing Address: Same as ☐ Guardian-1 ☐ Guardian-2

____

____

Work #: (______)_____________________________________

Home #: (______)____________________________________

Cell #: (______)______________________________________

Email: ____

PRIMARY DENTAL INSURANCE

Dental Insurance: ____________________________________

Name of Insured: ____________________________________

DOB: ____ /____ /_______ SSN: _____________________

Employer: ____

Policy #: ____

Group #: ____

SECONDARY DENTAL INSURANCE

Dental Insurance: ____________________________________

Name of Insured: ____________________________________

DOB: ____ /____ /_______ SSN: _____________________

Employer: ____

Policy #: ____

Group #: ____

REFERRAL INFORMATION

☐ Sibling(s): ____

☐ Friend: ____

☐ Pediatrician/Physician: _____________________________

☐ Dentist/Dental Office: ______________________________

☐ Insurance: ____

☐ School/Daycare: ___________________________________

☐ Other: ____

☐ Google ☐ Website ☐ Facebook/Instagram

☐ Print Ad (magazine, newspaper, etc.): _______________

☐ Community Event: ___________________________________

DENTAL HISTORY

What is the primary reason for today's visit?: ______________

____

Has your child ever been to the dentist?: ☐ Yes ☐ No

(If Yes) Previous/Present Dentist: ________________________

Date Last Exam: ____ /____ /_______

Date Last X-rays: ____ /____ /_______

Describe your Child: ☐ Outgoing ☐ Shy ☐ Anxious

☐ Frightened ☐ Stubborn ☐ Age Appropriate

How would you expect your child to behave in our office?

____

How may we help make this visit a positive experience for your child? ____

____

Have there been any injuries to the teeth, face, or mouth?:

☐ Yes ☐ No If Yes, please explain: ___________________

____

____

DENTAL HABITS (Check all that apply)

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Use Pacifier

☐ Clench/Grind Teeth ☐ Bite/Chew Nails

☐ Mouth Breather

☐ Bottle Feeding Until what age?________________

☐ Breast Feeding Until what age?________________

DENTAL HYGIENE ROUTINE (Check all that apply)

☐ Fluoride Toothpaste ☐ Consume fluoridated water

☐ Fluoride Mouthwash

☐ Brushing by child: _____________________ /day

☐ Brushing by parent: _____________________ /day

☐ Dental floss: _____________________ /week

☐ Snacks between meals

– Type of snacks: _____________________________________

____

MEDICAL HISTORY

Are immunizations current? ☐ Yes ☐ No

Child's Physician: ______________________________________

Phone #: (______)_____________________________________

Date Last Exam: ____ /____ /_______

History of Hospitalization /Operations /Emergency Room Care /Recent Illness (explain): __________________________

____

____

Current Medications: __________________________________

____

Has your child been diagnosed and / or treated for any of the following? (Check all that apply)

☐ Blood Disorder/Anemia/Sick Cell Disease

☐ Abnormal Bleeding/Hemophilia

☐ Immune Disorder/HIV/AIDS ☐ Cancer/Tumor/Leukemia

☐ Heart Murmur/Defect/Surgery

☐ Epilepsy/Seizures/Convulsions

☐ Cerebral Palsy ☐ Kidney Problems ☐ Thyroid Disease

☐ Liver Disease/Jaundice/Hepatitis ☐ Diabetes

☐ Stomach/GI Disorder ☐ Premature/Low Birth Weight

☐ Asthma/Reactive Airway Disease

☐ Mental/Cognitive/Social Delay

☐ Congenital Birth Defects

☐ Cleft Lip/Palate ☐ Autism Spectrum ☐ ADD/ADHD

☐ Eating Disorder ☐ Speech Disorder

☐ Vision Problem/Glaucoma ☐ Hearing Problem

ALLERGIES:

☐ Medication: ______________________________________

☐ Food: ____

☐ Seasonal ☐ Hives ☐ Latex

☐ Other (Specify): ___________________________________

☐ Comments/Details: ________________________________

Is there anything that has not been covered on this form that you would like to share with us regarding your child's overall medical and dental history? ______________________________________

____

- -

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and 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.

NAME: ____

SIGNATURE: ____________________________________

RELATIONSHIP TO CHILD: ___________________________

DATE _____ /_____ /________