New Patient Form

Today's Date:

1. TELL US ABOUT YOUR CHILD

Child's Legal Name: _____

Preferred Name: _____

Legal Sex (please check one) ☐Female ☐ Male

Gender Identity (please specify as desired) _____

Child's Birthdate _____ Child's Age _____

School_____

Grade _____

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
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Mouth Trauma/Broken Tooth
- ☐ Toothache
- ☐ Discolored Teeth
- ☐ Teeth Grinding
- ☐ 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 their jaw/joint (TMJ/TMD)? ☐ Yes ☐ No
Does your child brush their teeth daily? ☐ Yes ☐ No
Does your child use fluoridated toothpaste? ☐ Yes ☐ No
Does your child floss their 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 ☐ Asthma ☐ Diabetes ☐ Pregnancy

☐ ADD/ADHD ☐ Autism Spectrum Disorder ☐ Hearing Impairment ☐ Reflux/GI problems

☐ Allergies to any drugs ☐ Cancer ☐ Hemophilia/Blood Disorders ☐ Rheumatic/Scarlet Fever ☐ Seizures

☐ Allergies to food ☐ Cardiac (heart conditions, including murmur) ☐ Hepatitis ☐ Tuberculosis

☐ Allergies to latex ☐ Congenital Birth Defects ☐ HIV+/AIDS ☐ Sedation

☐ Any Hospital Stays ☐ Any Surgeries ☐ Kidney/Liver Conditions ☐ Depression/Anxiety

☐ Developmental Delays/Disabilities ☐ None of the Above

If you checked any of the above medical conditions, or if you would like to discuss any other medical conditions your child has had please do so below:

_____

_____

List all drugs your child is currently taking:

_____

List all allergies (food, drug, latex, etc) 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

Are all of your child's vaccinations up to date? ☐ Yes ☐ No
If no, please specify: _____

_____

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 _____
SSN: _____
Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed.

Address: _____
_____
City State Zip

Employer: _____
Work #: _____
Home #: _____
Cell #: _____
Email Address: _____

6. SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION

(if different from above)

Name: _____
Relationship: _____ Birthdate _____
SSN: _____
Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed.

Address: _____
_____
City State Zip

Employer: _____
Work #: _____
Home #: _____
Cell #: _____
Email Address: _____

7. HOW DID YOU LEARN ABOUT OUR PRACTICE?

_____

8. WHO WILL BE ACCOMPANYING THE CHILD/CHILDREN TO THEIR VISIT?

Important note: the parent or guardian who accompanies the children is legally responsible for payment at 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 #: _____

10. PRIMARY DENTAL INSURANCE

Insurance Name: _____
Insurance Address: _____
_____
City State Zip
Insurance Phone: _____
Group #: _____

Policy Owner's Name: _____
Relationship: _____
Birthdate: _____
SSN: _____
Employer: _____

11. SECONDARY INSURANCE

Do you have 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 the 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/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: _____
_____
_____