New Patient (Child) Form

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

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

About Your Child

Name: _____
LAST FIRST INITIIAL

Nickname: _____

Birthdate: _____ ❑ Male ❑ Female

Social Security #: _____

Special interests, sports or hobbies: _____

_____

Home Address: _____ apt./condo # _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Referred by: _____

About You

Your Name: _____

Social Security #: _____

Relationship to Child: _____

Your Home address and phone, if different from child's: _____

Home Address: _____ apt./condo # _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Occupation: _____

Employer: _____

Work Phone: _____ Ext. _____

Cell Phone: _____

Dental Insurance Company #1

Dental Ins. Co. _____

Their Phone #: _____

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Their relationship to the child: _____

Their Social Security #: _____

Their Birthdate: _____

Their Employer: _____

Dental Insurance Company #2

Dental Ins. Co. _____

Their Phone #: _____

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Their relationship to the child: _____

Their Social Security #: _____

Their Birthdate: _____

Their Employer: _____

Please continue on back.

4. Dental / Medical History

Has your child been to the dentist before? ❑ Yes ❑ No

If yes, the approximate dote of last visit: _____

Are there any dental problems that you are aware of at present?

❑ Yes ❑ No

If yes, please explain: _____

_____

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Please rate your child's oral health. ❑ Good ❑ fair ❑ Poor

Is your child currently under the care of a physician? ❑ Yes ❑ No

Child's physician: _____

Their phone#: _____

The approximate date of last visit: _____

Please rate your child's medical health. ❑ Good ❑ Fair ❑ Poor

Is your child allergic to any drugs? ❑ Yes ❑ No

If yes, please list: _____

_____

Is your child taking any prescription drugs? ❑ Yes ❑ No

If yes, please list: _____

_____

Does your child need to be premedicated before dental treatment? ❑ Yes ❑ No

Has your child ever had any of the following medical conditions or problems?

(Check all that apply.)

❑ Heart Murmur

❑ Heart problems of any kind.

❑ Convulsions/Epilepsy

❑ Cancer

❑ Diabetes

❑ Rheumatic Fever

❑ HIV+/AIDS

❑ Hemophilia

❑ Bleeding problems of any kind.

❑ Hearing Impairment

❑ Hyperactive

❑ Any Operations

❑ Any stays in the hospital

Are there any other medical conditions or problems relating to your child?

❑ Yes ❑ No

If yes, please list: _____

_____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

I understand that the information that 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 also authorize the dental staff to perform the necessary dental services my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian_____ Date: _____ / _____ /_____

Thank you for filling out this form completely. it will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.