NEW PATIENT FORM

Patient Name: _____ Nickname:_____ Sex:_____

Address: _____

City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone:_____ Ok to text? **YES** **NO**

Date of Birth: _____ Age: :_____ School: _____

Preferred Language: _____ Hobbies:_____

Whom may we thank for this referral?: _____ Siblings we see: _____

If you would like us to file insurance claims on your behalf, please provide us with the following information. Otherwise, payment is the patient's responsibility on the day of service. Thank you.

Dental Insurance Information: ***(Please provide a copy of your Dental Insurance Card.)***

Name of Dental Insurance Company: _____

Dental Insurance Company Address: _____

Name of Policy Holder: _____

Social Security No: _____ Birthdate:_____

Employer: _____ Group No:_____

Employer Address:_____

Member ID #: _____

Who is Responsible for this account:_____

PARENT/GUARDIAN INFORMATION

Father:: _____ Mother Name:_____

DOB: _____ DOB:_____

Address (If different from child): _____ Address (If different from child): _____

_____ _____

Home/Cell Phone: _____ Home/CellPhone:_____

Work Phone:_____ Work Phone:_____

Email:_____ Email:_____

Who is responsible for child's account:_____

Emeregency Contact other than parent:_____

Who is accompanying your child today?: _____ Relationship: _____

Do you have legal custody of your child?: **YES** **NO** Is your child adopted? **YES** **NO**

Child lives with? _____**BOTH PARENTS** _____ **MOM** _____ **DAD** _____ **GRANDPARENTS** _____ **GUARDIAN**

I have listed two persons who might be involved in my child's dental appointments/updates and/or transportation.

_____ _____

Over

Medical History

Name of Primary Care Doctor: _____Phone Number:_____

Has your child been under the care of a Specialist in the past 2 years? **Yes** **No**

If **YES,** please explain: _____

Have your child been hospitalized/ or had surgery?: **Yes** **No**

If **YES,** please explain:_____

Does your child have any allergies? **YES** **NO**

If **YES**, please list: _____

Is your child taking any medications at this time? **Yes** **No**

If **YES**, please llist:_____

Date of last well check:_____ Is your child's immunizations up to date?_____

Circle any of the following which you have had or currently have:

- ADHD
- AIDS/HIV
- Anemia
- Asthma
- Autism
- Bladder Disease
- Blood Transfusion
- Bleeding Disorder
- Breathing Problems
- Cancer
- Chemotherapy
- Cold Sores/Fever Blisters
- Cerebral Palsy
- Convulsions
- Congenital Heart Disorder
- Diabetes
- Epilepsy/Seizures
- Frequent Headaches
- Hepatitis
- Hearin Disorder
- Heart Condition/Murmur
- Kidney Problems
- Liver Disorder
- Lung Disease
- Mononucleosis
- Down Syndrome
- Oral sensory disorder
- Neurological Disorder
- Pregnancy
- Respiratory Problems
- Sinus Problems
- Tuberculosis
- Behavioral/Emotional Problems

Other: _____

Dental Health

Is your child having dental problems at this time? **Yes** **No**

If yes, please explain: _____

Do you think your child will feel nervous about having dental work done?: **Yes** **No**

Has your child been seen by another dentist? If **YES;** who? _____ Last visit: _____

Who is responsible for your child's teeth cleaning? **CHILD**_____ **PARENT** _____**BOTH**_____

How often does your child brush? _____ Was your child breast fed? _____ Bottle fed? _____

Does your child? (**PLEASE CHECK ALL THAT APPLY)**

_____Suck thumb/finger _____Suck/bite lips _____Grinds Teeth _____Pacifier

_____Bite/chew nails _____Chew hard objects _____ Clinch Jaw

PARENT SIGNATURE:_____ **DATE:**_____

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION TO THIRD PARTY PAYERS AND/OR OTHER HEALTHCARE PRACTIONERS, IF NECESSARY. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST BENEFITS OTHERWISE PAYABLE TO ME.