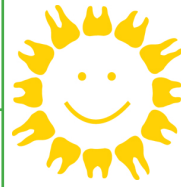


New Patient Form



bright smiles
PEDIATRIC DENTISTRY

Today's Date: _____

1 TELL US ABOUT YOUR CHILD

Child's Name: _____

Nickname: _____ Male Female

Child's Birthdate: _____ Child's Age: _____

School: _____

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?

- | | |
|--|---|
| <input type="checkbox"/> Lip Sucking / Biting | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> Nursing / Bottle Habits | <input type="checkbox"/> Thumb / Finger Sucking |
| <input type="checkbox"/> Tobacco Use | |

Does your child have any current dental issues?

- | | |
|--|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Discolored Teeth |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Mouth Trauma/Broken Tooth | <input type="checkbox"/> 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 his/her jaw/joint? (TMJ/TMD)? Yes No

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

Does your child floss his/her teeth daily? Yes No

Does your child have tooth or mouth pain today? 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?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Asthma | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Reflux/GI Problems |
| <input type="checkbox"/> Allergies to Any Drugs | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Allergies to Latex Products | <input type="checkbox"/> Cardiac (Heart Conditions) | <input type="checkbox"/> Hemophilia/Blood Disorders | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Any Hospital Stays | <input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Any Operations | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> HIV + / AIDS | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Liver Conditions | <input type="checkbox"/> None of the Above |

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

List all drugs your child is currently taking.

List all allergies your child currently has.

Child's Physician: _____

Phone #: _____

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

Are all immunizations up to date? Yes No

Please describe your child's current physical health:

Good Fair Poor

5 PARENT OR LEGAL GUARDIAN'S INFORMATION

The information in this section applies to the legal caregiver of the child / children.

Name: _____

Relationship: _____ Birthdate: _____

Marital Status:

Single Married Divorced Widowed

Address: _____

City _____ State _____ Zip _____

SSN: _____ DL#: _____

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

Email Address: _____

Preferred Contact Method (check all that apply):

Cell Phone Home Phone Email Text

Preferred Contact Method for Confirmations (check all that apply):

Cell Phone Home Phone Email Text

6 SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION

(If different from #5 above.)

Name: _____

Relationship: _____ Birthdate: _____

Marital Status:

Single Married Divorced Widowed

Address: _____

City _____ State _____ Zip _____

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

SSN: _____ DL#: _____

Email Address: _____

7 HOW DID YOU LEARN ABOUT OUR PRACTICE

Internet Search Word of Mouth Dental Insurance Website Other (Please Write Below)

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

Important Note: The parent or guardian who accompanies the child is legally responsible for payment at the 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 #: _____

Email Address: _____

10 PRIMARY DENTAL INSURANCE

Insurance Name: _____

Policy Owner's Name: _____

Insurance Address: _____

Relationship: _____

City _____ State _____ Zip _____

Birthdate: _____

Insurance Phone: _____

SSN: _____

Group #: _____

Employer: _____

11 DUAL (SECONDARY) INSURANCE

Do you have dual (secondary) insurance? Yes No

Insurance Name: _____

12 SIGNATURE

I understand that the information I have given is correct to the best of my knowledge, that it 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 may need.

Signature of Parent or 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.

Doctor's Comments _____

Initials _____ Date _____
