



New Patient Information

About Your Child

Child's Name: _____

Nickname: _____

Gender: Male Female Date of Birth: _____

SSN _____

Address: _____

City: _____ State: _____

Zip: _____ Home Phone: _____

Where did you find out about us? _____

School/Daycare does patient attend? _____

Favorite Movie: _____ Book: _____

List any sports or hobbies: _____

Parent's Marital Status:

Married Divorced Separated

Widowed Single

Dental History

Yes No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child?

Yes No Do you expect your child to be a cooperative patient? If no, please explain.

Yes No Does your child take fluoride tablets or vitamins with fluoride?

Yes No Has your child bumped any teeth? If so, when? _____

Yes No Has your child had a history of headaches, pain, popping or clicking of the jaws?

Yes No Does your child have a toothache? _____

Does your child have any of the following problems or habits?

Thumb Sucking How Long? _____

Finger Habit How Long? _____

Pacifier How Long? _____

Medical History

Family Physician's Name: _____

Address: _____

Phone Number: _____

• Does your child have to pre-medicate? Yes No

• Is your child in good health? If no, explain Yes No

• Is your child under the care of a physician for anything other than routine care? If yes, explain Yes No

• Does your child have any allergies? Yes No

• Is your child taking any medications? Yes No
If yes, list. _____

Please indicate if your child has had any of the following:

Allergy to Penicillin

Intellectual disability

Anemia

Latex allergy

Asthma

Liver problems

Hepatitis

Autism/Asperger's

Malignancies or leukemia

Bleeding disorder

Other drug allergy

Bone disorder

Physical handicap

Cleft palate

Positive for H.I.V.

Diabetes

Radiation treatment

Endocrine disorder

Rheumatic fever

Epilepsy, seizures

Speech problem

ADD/ADHD

Tuberculosis

Heart ailment or murmur.

Type: _____

Is child under the care of a cardiologist or special physician for the problem?

If so, whom _____

Phone _____

Please comment on any problems that were checked in the above areas



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Dental History

How often does your child brush? _____

Is tooth brushing supervised? Yes No

By whom? _____

Is dental floss used? Yes No

Emergency Contact

Name: _____

Address: _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

Responsible Party

Father's Full Name: _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Email Address _____

Dental Insurance: Yes No

Insurance Company _____

Group or Plan Number _____

Insurance Company Phone _____

Mother's Full Name: _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Email Address _____

Dental Insurance: Yes No

Insurance Company _____

Group or Plan Number _____

Insurance Company Phone _____

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays, and examinations) before that treatment is performed.

SIGNED (parent or legal guardian)

DATE