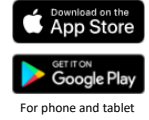
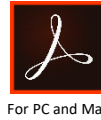


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# New Patient Form

Today's Date: \_\_\_\_\_

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service

## 1. Tell Us About Your Child

Child's Name: \_\_\_\_\_  
Goes by: \_\_\_\_\_ Male Female  
Siblings That We Treat: \_\_\_\_\_  
Child's Birthdate: \_\_\_\_\_ Child's Age: \_\_\_\_\_  
School: \_\_\_\_\_  
Child's Home Phone #: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_

## 2. Legal Guardian #1 Information

Name: \_\_\_\_\_  
Mother Father Stepparent Guardian  
Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_  
SSN: \_\_\_\_\_ DL #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

## 3. Legal Guardian #2 Information

Name: \_\_\_\_\_  
Mother Father Stepparent Guardian  
Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_  
SSN: \_\_\_\_\_ DL #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

## 4. Who May We Thank for Referring You?

\_\_\_\_\_

## 5. Who Is Accompanying Your Child Today?

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Do you have legal custody of this child? Yes No

## 6. Person Responsible for Account

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Work Phone #: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Cell Phone #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

## 7. Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone#: \_\_\_\_\_  
Group# (Plan, local, or Policy #): \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_

## 8. Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_  
Group# (Plan, local, or Policy #): \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_

## 9. 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: \_\_\_\_\_

Were any x-rays taken at previous dental visits? Yes No

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 the child have any of the following habits?

Lip sucking / Biting      Nail Biting  
Nursing / Bottle Habits      Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain:

Is the child's water fluoridated?

Is the child taking fluoride supplements?

Has the child ever had any pain or tenderness in his/her jaw/joint (TMJ/TMD)?

Does the child brush his/her teeth daily?

Floss his/her teeth daily?

## 10. Health History

Has the child ever had any of the following conditions?

Abnormal Bleeding	Handicaps/Disabilities
Allergies to any Drugs	Hearing Impairment
Any Hospital Stays	Heart Disease/Murmur
Any Operations	Hepatitis
Asthma	HIV +/-AIDS
Cancer	Kidney/Liver Conditions
Congenital Birth Defects	Rheumatic/Scarlet Fever
Convulsions/Epilepsy	Allergies to Latex Product
Pregnancy	Diabetes
Tuberculosis	Hemophilia/Blood Disorders
ADD/ADHD	Reflux/GI problems
Autism	

Please discuss any serious medical conditions the child had:

Please list all the drugs the child is currently taking:

Please list all drugs the child is allergic to:

Have you or any of your household members traveled outside the US within the last 60 days? If yes, where?

Child's physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

Please describe the child's current physical health:

Good Fair Poor

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


**I understand that the information I have give 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 change in my child medical status.**

I authorize the dental staff to perform the necessary dental service my child may need.

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Signature of Patient or Guardian:

Click  icon on the toolbar to add the digital signature. \_\_\_\_\_