Pediatric Dentistry

New Patient Form: Children Over 1 Year

We would like to welcome you and your child to our office! Our practice goal is to improve the lives of children by optimizing their oral health which will benefit their overall wellness. We will accomplish this state of the art treatment with a friendly approach focusing on the child's special needs. Please fill out this form, print, sign, and bring with you to your appointment.

Patient Information

Name:______________________________ Nickname:______________________

Date of Birth:______________ Male Female Social Security #______________________

Home Address:____

Parent/Guardian Information

Name:______________________________ Relationship to patient:______________________

Home Address (if different): ____

Phone numbers: Home: ______________ Work: ______________ Mobile:______________

Email Address: ____

Dental Insurance Information

Insurance Company Name:______________________________ Group #:______________

Insurance Company Phone: ______________ Insured Name: ______________________

Relationship to patient: ____

Insured SSN: ______________________________ Insured Date of Birth:______________

Insured Employer:____

Referred By: ____

Last Dental Exam: ______________________ By Dr. ______________________________

Past Dental Treatment: ____

Name:__________________

Medical History

Has your child had any of the following conditions?

- ☐ Anemia
- ☐ Asthma/Lung Problems
- ☐ Kidney Disease
- ☐ Bleeding Disorder/Hemophilia
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Cleft Palate
- ☐ Delayed Development
- ☐ Pregnant
- ☐ Cancer
- ☐ Emotional Disturbance
- ☐ Heart Condition/Murmur
- ☐ Failure to Thrive/Low Weight
- ☐ Immunologic Disorder/HIV
- ☐ Hearing Impairment
- ☐ Liver Disease/Jaundice
- ☐ Sickle Cell Anemia
- ☐ Premature Birth (__weeks)
- ☐ Diabetes/Endocrine Disorder
- ☐ Intellectual Disability
- ☐ Seizures/Epilepsy
- ☐ Autistic Spectrum Disorder/ Aspergers

Any problems not listed above ☐ No ☐ Yes:______________________________

Please list all medications your child is currently taken: ☐ None

____

Is Your Child ALLERGIC or has your child had an ADVERSE REACTION to any medication?

☐ No ☐ Yes: ______________________________

Surgeries or Anesthesia History: ☐ None ☐ Yes:______________________________

Any history of life-threatening anesthesia complications in the family? ☐ No ☐ Yes:______________

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Primary Physician/Pediatrician:______________________________

Other Physicians/Specialists:______________________________

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's medical status.

I have had full opportunity to read the Consent form and Notice of Privacy Practices (HIPAA).

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved. I have had full opportunity to read the Office Financial Policies.

Parent/Guardian Name______________________________Date:__________

Signature:______________________________