



Pediatric
Dentistry

New Patient Form

Children Under 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: _____ Date of Birth: _____ Relationship to Patient: _____
Phone Numbers: Home: _____ Work: _____ Mobile: _____
Email Address: _____

Dental Insurance Information

Insurance Company Name: _____ Group Number: _____
Insurance Company Phone: _____ Insured Name: _____
Relationship to Patient: _____ Insured SSN: _____
Insured Date of Birth: _____ Insured Employer: _____

Medical History

Full Term Birth or Premature Birth: _____ Weeks.
Any birth complications? No Yes: _____
Any medical issues after birth? No Yes: _____
 Hospital Birthing Center Home Birth Birth Weight: _____ Current Weight: _____
 Breast Feeding Bottle Feeding: Breastmilk Formula: _____

Breastfeeding Problems:

Latch Issues Lip Blister Feeding Frequency
 Milk Transfer Issues Staying on Breast Reflux
 Excessive Air/Gas Long BF Session

Maternal Pain/Symptoms: _____
 Lactation Consultant: _____

Child's Name: _____

Medical History

Has your child had any of the following conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/Lung Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease/Hepatitis/Jaundice |
| <input type="checkbox"/> Diabetes/Endocrine Disorder | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Bleeding Disorder/Hemophilia |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Heart Condition/Murmur | <input type="checkbox"/> Autistic Spectrum Disorder/Aspergers |
| <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Syncope/Fainting Spells | <input type="checkbox"/> Immunologic Disorder/HIV | |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizures/Epilepsy | |

Any problems not listed above No Yes: _____

Please list all medications your child is currently taking: 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: _____

Primary Physician/Pediatrician: _____ Date of Last Exam: _____

Is your child up to date on their vaccines? Yes No

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 give consent to the doctors to exam my child.

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: _____