Sierra kids Smiles Pediatric Dentistry

New Patient Form

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:_____

Dental History

Is this your child's first visit to a dentist? ☐ Yes ☐ No

If no, what is the approximate date of last visit?_____

Referred by:_____

Is your child's home supplied with well water or city water? _____

Does your child receive fluoride tablets, drops, vitamins, or rinse?_____

Does your child brush his or teeth daily? ☐ Yes ☐ No Do you assist them? ☐ Yes ☐ No

Does your child suck his or her thumb or finger, or have any similar habits? _____

At what age did you stop bottle or breast feeding?_____

Has your child ever had orthodontic treatment?_____

Has your child complained about pain, swelling or other problems?_____

Are you and your child happy with his/her facial appearance?_____

Appearance of their teeth?_____

Would you predict your child's behavior to be: ☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't Know

What are your concerns about your child's oral health?_____

_____

Child's Name:_____

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Medical History

Has your child had any of the following conditions?

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

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:_____