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New Child Patient Information (Patients under 18 years old)

Please let us know about your child's medical and dental history so we may serve you more effectively and in a manner that helps with the overall health and well-being of your child.

We realize that not all questions will pertain to your child. If you have questions, please ask and we will help to better explain the question.

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **Prev. Visit:** ________ **Email Address:** ____________

Phone: ________ Home ________ Mobile ________ Work ____ Ext **Best time to call:** ________

Address: ____________ Address 1 ____________ Address 2

____________ City ____ State ____-____ Zip Code

Who does the child live with?

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

Siblings who are or who have been a patient in our office:

____

____

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child? ◯ Yes ◯ No

What is the reason for seeing the dentist today?

☐ First Visit ☐ Check-up ☐ Pain ☐ Other

Guardian Information

Unless information is different, this form need only be completed for one child.

Please complete this information on the next page.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **DL#:** ______________

Email Address: ______________ **Best time to call:** ______________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________ ______________
Address 1 Address 2

______________ ____ _____-____
City State Zip Code

Employer

____

____

Other Guardian Information

Unless information is different, this form need only be completed for one child.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **Email Address:** ______________

Phone: ________ ________ ________ ____ **Best time to call:** ______________
Home Mobile Work Ext

Address: ______________ ______________
Address 1 Address 2

______________ ____ _____-____
City State Zip Code

Employer

____

____

Dental Benefits Plan

Primary

Name of Insured: ______________ ______________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________

Please provide a copy of the insurance card to our front desk. Thank you.

Child's Medical & Dental History

Within the past year have there been any changes in your child's general health? ◯ Yes ◯ No

What is the approximate date of your child's last medical exam? ____________

Your child's pediatrician name and phone number:

____

____

Please indicate if your child has experienced any of the following.

☐ Allergies Other	☐ Allergy Amoxicillin	☐ Allergy Aspirin	☐ Allergy Clindamycin
☐ Allergy Codeine	☐ Allergy Ibubrofen	☐ Allergy Latex	☐ Allergy NEOSPORIN
☐ Allergy Penicillin	☐ Allergy Sulfa	☐ Allergy Tetracyline	☐ Aneurism
☐ Asthma	☐ Brain Shunt	☐ Cancer	☐ Celiac disease
☐ Chronic Fatigue	☐ Chronic Headaches	☐ Diabetes	☐ Diverticulitis
☐ Epilepsy	☐ Fibromyalgia	☐ GERD	☐ Heart Disease
☐ Heart Murmur	☐ Heart Valve Clip	☐ Hepatitis	☐ High Blood Pressure
☐ Joint Replacement	☐ Migraines	☐ Mitral Valve Surgery	☐ NO EPI
☐ NO NEED TO PREMED	☐ Neuropathy	☐ Osteoporosis	☐ Over active bladder
☐ PRE MED	☐ Pacemaker	☐ Parkinsons Disease	☐ Platelet aggregation disorder
☐ Respiratory Problems	☐ Stroke	☐ UTI	

☐ Had complications with or after dental treatment.

☐ Has been seen by a cardiologist.

☐ Taking any prescription or non-prescription medications.

☐ Any other conditions, diseases, etc. not listed above.

☐ Currently under the care of a physician due to a specific condition.

☐ Been admitted to a hospital in the last 5 years due to a surgery or illness.

☐ Tobacco use (chewing or smoking.)

If any of the previous questions are marked, please explain:

____

____

Has your child been to a different dental office in the last 6 months? ◯ Yes ◯ No

What was done at your child's last dental visit, if to a different office?

____

____

How frequently does you child brush their teeth?

☐ 3+ a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom ☐ By parent ☐ By child ☐ Both

Is your child taking a fluoride supplement? ◯ Yes ◯ No

How often does your child floss?

☐ Once daily ☐ Occasionally ☐ Never ☐ By parent ☐ By child

Does your child do any of the following?

☐ Lip sucking/biting ☐ Pacifier ☐ Nail biting ☐ Finger/thumb sucking ☐ Nursing/bottle ☐ Grinds his teeth ☐ Snores

Consent for Services

☐ **To the best of my knowledge, all of the preceding information is true and correct. If there is any change in my child's health I will inform the office at my child's next dental appointment.**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnoses and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice, to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Relationship to Patient:

☐ Mother ☐ Father ☐ Guardian ☐ Other

☐ **By checking this box, I acknowledge that I have read this statement and agree to the contents.**

Relationship to patient

☐ Mother ☐ Father ☐ Guardian ☐ Other

Response Date: ____________