NEW PATIENT INFORMATION FORM (CHILD)

PLEASE FILL OUT BOTH SIDES OF THIS SHEET. THANK YOU.

PATIENT INFORMATION DATE: ___________

NAME: (last) ________________________ (first) ____________________ (middle) _______________

NICKNAME: ________________ BIRTHDATE: _____/_____/_____ AGE: ______________

GENERAL DENTIST: ___________________________ PHYSICIAN: _________________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?: ________________________

WHAT IS YOUR CHIEF CONCERN THAT BRINGS YOU TO OUR OFFICE?: _____________________

____

CONTACT INFORMATION

RESPONSIBLE PARTY #1 RELATIONSHIP TO PATIENT ____________________________

FIRST NAME: _______________________ LAST NAME: _____________________________

ADDRESS: (street)_______________________ (city)_______________ (state)_______ (zip)__________

HOME#: __________________ WORK #: ____________________ CELL #: _____________________

EMAIL ADDRESS: __________________________________ CELLULAR PROVIDER _____________

EMPLOYER: ______________________________ OCCUPATION: ________________________

RESPONSIBLE PARTY #2 RELATIONSHIP TO PATIENT ____________________________

FIRST NAME: _________________________ LAST NAME: ___________________________

ADDRESS: (street)________________________ (city)_________________ (state)______ (zip)__________

HOME#: __________________ WORK#: _____________________ CELL#: _____________________

EMAIL ADDRESS: __________________________________ CELLULAR PROVIDER ______________

EMPLOYER: ______________________________ OCCUPATION: ________________________

DENTAL INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO OUR RECEPTIONIST SO THAT WE MAY MAKE A COPY OF IT FOR OUR RECORDS.

PATIENT'S SOC. SEC. #: ____

RESPONSIBLE PARTY #1 SSN: ___________________________ DATE OF BIRTH: ______________

RESPONSIBLE PARTY #2 SSN: ___________________________ DATE OF BIRTH: ______________

OVER →

MEDICAL AND DENTAL HISTORY

PLEASE DESCRIBE ANY IMPORTANT MEDICAL HISTORY OF WHICH WE SHOULD BE AWARE?:

____

IS THE PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, DESCRIBE: ________

____

IS THE PATIENT CURRENTLY TAKING ANY MEDICATIONS, INCLUDING PRESCRIPTION AND/OR OVER-THE-COUNTER? ____

DOES THE PATIENT HAVE A HISTORY OF HEART MURMUR, PROSTHETIC HEART VALVES, RHEUMATIC FEVER, OR ANY OTHER CONDITION THAT MAY REQUIRE PREMEDICATION WITH ANTIBIOTICS PRIOR TO DENTAL TREATMENT? IF YES, PLEASE DESCRIBE: __________________

____

IS THE PATIENT ALLERGIC TO ANY MEDICATIONS?: WHICH? : ______________________________

IS THE PATIENT ALLERGIC TO LATEX?: YES NO

HAVE THE PATIENT'S TONSILS BEEN REMOVED?: YES NO ADENOIDS?: YES NO

IS THE PATIENT EXPERIENCING ANY PAIN, POPPING OR CLICKING SOUNDS, FACIAL PAIN, OR ANY OTHER DYSFUNCTION IN THE AREA OF THE JAW JOINTS (TMJ)? YES NO

IF YES, PLEASE REQUEST A TMJ QUESTIONNAIRE FROM THE RECEPTIONIST TO ASSIST US WITH OUR EXAMINATION AND DIAGNOSIS OF THE PATIENT.

HAS THE PATIENT BEEN INVOLVED IN ANY ACCIDENT WHICH HAS CAUSED INJURY TO THE TEETH OR JAWS? IF YES, DESCRIBE, AND GIVE THE DATE OF TRAUMA: ______________________

____

PLEASE CIRCLE HISTORY OF ANY OF THE FOLLOWING IMPORTANT HABITS, IF PRESENT:

THUMB/FINGER SUCKING TONGUE THRUST NAIL BITING LIP/CHEEK BITING SMOKING

FOR YOUNG GIRLS ONLY: IN ORDER FOR US TO ASSESS THE GROWTH STATUS AND STAGE OF PHYSICAL MATURATION OF THE PATIENT, PLEASE INDICATE THE FOLLOWING:

HAS MENSTRUATION BEGUN?: YES NO IF YES, WHEN?: ____________________________