

New Patient Information

Date _____

(Please print)

Child's Name _____ Nickname _____
First Middle Last

Social Security # _____ Birthdate _____ Male Female

Child's Address: Street _____

City _____ State _____ Zip _____

Home Phone _____ Siblings who are seen at this practice _____

Child resides with: Mother Father Other Specify _____

What is your main concern about your child's dental health? _____

Fluoride History

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Is your home water supply fluoridated? Water Company _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your child use a fluoride toothpaste? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were they using it before three (3) years old? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you give your child any other form of fluoride? What? _____ |
| | | Child's school/preschool _____ |

Health History

Child's Physician _____ Physicians Phone no. _____

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Does your child have a heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Is your child currently on any medication? List _____ Dosage _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has your child ever been allergic or had an unfavorable reaction to food, medication, toys, or balloons?
Please describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Does your child have asthma or seasonal allergies? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has your child ever been given a blood transfusion? Date _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Does your child have any medical conditions? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has your child ever been to a dentist? Name/Date _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has your child ever had a negative dental experience? Please describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Does your child suck a finger, thumb or pacifier? |

Parent/Guardian Information

Mother's Name _____

Mother's Address: Street _____

City _____ State _____ Zip _____

Previous Address (If less than 3 yrs.) _____

Mother's Home Phone No. _____ Cell No. _____

Email Address _____

Employer _____ Work No. _____

Mother's SS# _____ Date of Birth _____

Father's Name _____

Father's Address: Street _____

City _____ State _____ Zip _____

Previous Address (If less than 3 yrs.) _____

Father's Home Phone No. _____ Cell _____

Email Address _____

Employer _____ Work No. _____

Father's SS# _____ Date of Birth _____

Whom may we thank for referring you to our office? _____

Treatment Consent (or Signature) Signature

Since _____ is a minor, it is necessary that signed permission be obtained from a parent or guardian before dental services are rendered. Authorization for dental service is hereby granted as such.

Signed _____ Date _____
Parent or Guardian

Payment is requested at the time professional services are rendered unless prior arrangements are made. I will be responsible for any fees incurred on this account.

Signed _____ Date _____
Parent or Guardian