Dr. Bob
PEDIATRIC DENTIST

New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: ______________________
Last First Middle

Goes by: ______________ ☐ Male ☐ Female

Siblings that we treat: ______________________

Child's Birthdate: ____/____/____ Child's Age: ________

School: ______________________

Child's Home #: (____)______________________

SSN: ______________________

Child's Home Address: ______________________

____
City State Zip

2 GUARDIAN'S INFORMATION

Name: ______________________

Birthdate ____/____/____

Address: ______________________

____
City State Zip

Employer: ______________________

Work #: (____)______________________

Home #: (____)______________________

Cell #: (____)______________________

SSN: ______________ DL#: ______________

Email Address: ______________________

3 GUARDIAN'S INFORMATION

Name: ______________________

Birthdate ____/____/____

Address: ______________________

____
City State Zip

Employer: ______________________

Work #: (____)______________________

Home #: (____)______________________

Cell #: (____)______________________

SSN: ______________ DL#: ______________

Email Address: ______________________

4 WHO MAY WE THANK FOR REFERRING YOU?

____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: ______________________

Relationship: ______________________

Do you have legal custody of this child? ☐ Yes ☐ No

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________

Relationship: ______________________

Billing Address: ______________________

____
City State Zip

Work #: (____)______________________

Home #: (____)______________________

Cell #: (____)______________________

Email Address: ______________________

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

____
City State Zip

Insurance Co. Phone #: (____) ______________________

Group # (Plan, Local, or Policy #): ______________________

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ____/____/____

SSN: ______________________

Policy Owner's Employer: ______________________

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

____
City State Zip

Insurance Co. Phone #: (____)______________________

Group # (Plan, Local, or Policy #): ______________________

Policy Owner's Name: ______________________

Relationship to Patient: ______________________

Policy Owner's Birthdate: ____/____/____

SSN: ______________________

Policy Owner's Employer: ______________________

9 DENTAL HISTORY

Is this your child's first visit to the dentist? ____________

If not, how long since the last visit to the dentist? ____________

Previous dentist's name: ____________

Were any x-rays taken at previous dental visits? ____________

Have there been any injuries to the teeth, face or mouth? ____________

If yes, please explain: ____________

____

____

Why did you bring your child to the dentist today? ____________

____

____

Does the child have any of the following habits?

Y	N	Lip Sucking / Biting	Y	N	Nail Biting
Y	N	Nursing / Bottle Habits	Y	N	Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: ____________

____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his / her teeth daily? YES NO

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y	N	Abnormal Bleeding	Y	N	Handicaps/Disabilities
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Disease/Murmur
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV + / AIDS
Y	N	Cancer	Y	N	Kidney/Liver Conditions
Y	N	Congenital Birth Defects	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions/Epilepsy	Y	N	Allergies to Latex Product
Y	N	Pregnancy	Y	N	Diabetes
Y	N	Tuberculosis	Y	N	Hemophilia/Blood Disorders
Y	N	ADD/ADHD	Y	N	Reflux/GI Problems

Please discuss any medical conditions the child has had:

____

____

Please list all the drugs the child is currently taking: ____________

____

Please list all drugs the child is allergic to: ____________

____

Child's Physician: ____________

Phone #: (____) ____________

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:

GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11 I understand that the information I have give is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____________ ____________

Signature of Parent or Guardian Date Relationship to Patient

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials ____________ Date ____________

Doctor's Comments ____________

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