Child New Patient Form

Patient's Name:	**DOB:**	**SS#:**	
Parent/Guardian's Name:	**Parent's Email:**		
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		
Emergency Contact:	**Emergency Contact Phone:**		
Who may we thank for referring you:			

Insurance

Do you have dental insurance?	**Yes**	**No**	**Please provide your insurance card to the front desk so that we can file claims on your behalf.**

Does the child have any of the following:

Teeth that are sensitive to hot, cold, or sweets	Yes	No
Teeth that are painful	Yes	No
Sores or lumps in or near the mouth	Yes	No
Speech difficulties	Yes	No
Has the child ever had problems with dental treatment?	Yes	No
Has the child ever had orthodontic treatment (braces)?	Yes	No
Has the child ever had a serious injury to the jaw?	Yes	No
Has the child ever had any problems with shedding or eruption of teeth?	Yes	No

Does the child do any of following:

Snore while sleeping	Yes	No
Gasp for air or choke while sleeping	Yes	No
Breathe through their mouth during sleep	Yes	No
Breathe through their mouth throughout the day	Yes	No
Awake during the night and have trouble falling back to sleep	Yes	No

What is the reason for today's visit?	
Date of last dental treatment:	**What was done at that time?**

Does the child have any of the following conditions?

High Blood Pressure	Yes	No	**Please list any other health conditions that the child has::**
Heart Murmur	Yes	No	
Mitral Valve Prolapse	Yes	No	
Damaged Heart Valve	Yes	No	
Artificial Heart Valve	Yes	No	
Infective Endocarditis	Yes	No	
Congenital Heart Defect	Yes	No	
Hemophilia	Yes	No	
Abnormal Bleeding	Yes	No	
Cancer	Yes	No	
Bone or Joint Problems	Yes	No	
Diabetes Type I or Type II	Yes	No	
Kidney Disease	Yes	No	
Liver Disease	Yes	No	
Migraine Headaches	Yes	No	
Thyroid Problems	Yes	No	
Acid Reflux	Yes	No	
Bulimia	Yes	No	
Ulcerative Colitis/Crohn's	Yes	No	
AIDS or HIV	Yes	No	
Hepatitis	Yes	No	
Tuberculosis	Yes	No	
Emotional/Mental Impairment	Yes	No	

Please List Current Medications :	**Please List Medication Allergies:**		
	Is the child allergic to latex?	**Yes**	**No**

Signature of Parent/Guardian:_____ **Date:**_____