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

Subscriber's Name:	**Insurance Company:**
Subscriber's SS#:	**Employer:**
Subscriber's DOB:	**Group #:**
Subscriber's Relationship to the Patient:	

Dental History

Does the child have teeth that are sensitive to hot, cold, or sweets?	Yes	No
Does the child have any teeth that are painful?	Yes	No
Does the child have any sores or lumps in or near the mouth?	Yes	No
Does the child have any 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 take fluoride supplements?	Yes	No				
Is fluoride toothpaste used?	Yes	No				
What type of water does the child predominately drink? (circle one)	City	Well	Bottled			
How many times/day are the child's teeth brushed? (circle one)	None	1	1-2	2	2-3	3

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

Does the child have or ever had any of the following conditions?

High Blood Pressure	Yes	No
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
Pacemaker	Yes	No
Heart Attack	Yes	No
Stroke	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
Frequent Sinus Infections	Yes	No
Acid Reflux	Yes	No
Bulimia	Yes	No
Colitis/Crohn's Disease	Yes	No
Gastrointestinal Disease	Yes	No
AIDS or HIV	Yes	No
Hepatitis	Yes	No
Tuberculosis	Yes	No
Emotional/Mental Impairment	Yes	No

Please list any other health condition that you think we should know about:

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

Signature of Parent/Guardian:______________________________________ **Date:**__________________