NEW PATIENT FORM - CHILD

This form is to be used for patients under the age of 18.

PATIENT INFORMATION

Patient Name ______________________________

Nickname or Preferred Name ______________________________

Date of Birth ____________________ Patient's Age ______________

Address ______________________________ City ______________

State __________ Zip ____________ Phone ______________________

Please List Other Siblings and Their Ages ______________________

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Other Family Members Treated at Our Office ______________________

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Who Referred You to Our Office? ______________________________

______________________________ ______________________________

Name of Child's Dentist Approximate Date of Last Visit

PARENT GUARDIAN 1

Parent/Guardian Full Name #1 ______________________________

Relationship to Patient ______________________________

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

Phone ______________ Email ______________________________

Parent/Guardian Address (If Different from Patient's)

Address ______________________________

City ______________ State ________ Zip ________

PARENT GUARDIAN 2

Parent/Guardian Full Name #2 ______________________________

Relationship to Patient ______________________________

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

Phone ______________ Email ______________________________

Parent/Guardian Address (If Different from Patient's)

Address ______________________________

City ______________ State ________ Zip ________

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account ________________________________

Relationship to Child ________________________________

Dental Insurance Company ________________________________

Subscriber Date of Birth ________________________________

MEDICAL HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Physician Name ________________________________
First Last

Date of Last Visit ________________________________

Current Physical health is: Good Fair Poor

Have Tonsils or Adenoids been removed? Yes No

Has puberty begun? Yes No

For Females: Has menstruation begun? Yes No

Is the child taking prescription/over-the-counter medications? Yes No

Has the child ever had any of the following medical problems or diseases?

Abdominal bleeding/Hemophilia
Anemia
Artificial Bones/Joints/Valves
Asthma
Blood Transfusion
Cancer/Chemotherapy
Congenital Heart Defect
Difficulty Breathing
Colitis
Diabetes
Emphysema
Epilepsy
Fainting Spells
Frequent Headaches
Glaucoma
Hay Fever
Heart Attack/Surgery
Heart Murmur
Hepatitis
Herpes/Fever Blisters
High Blood Pressure
HIV/AIDS
Kidney Problems
Latex Allergy
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Nickel Allergy
Psychiatric Problems
Rheumatic/Scarlet Fever
Shingles
Sinus Problems
Thyroid Problems
Prosthetics
Radiation Treatment
Seizures
Sickle Cell Disease
Stroke
Tuberculosis
Any Hospitalization

Does the child have any of the following habits?

Clenching/Grinding Teeth
Lip Sucking/Biting
Mouth Breathing
Nail Biting
Speech Problems
Thumb/Finger Sucking
Tongue Thrust
Pacifier Usage

Has the child ever been evaluated for orthodontic treatment? Yes No

Has the child ever experienced pain or discomfort in the jaw joint (TMJ/TMD)? Yes No

Has the child ever had an injury to their: (Select all that apply) Mouth Teeth Chin

ATTESTATION

I understand that the information provided in this form is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. I understand that I am responsible for payment of services rendered and for any co-payment that my insurance does not cover, including the deductible. I understand that I am responsible for all costs of orthodontic treatment. I herby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

Signature of Parent or Guardian * ______________________________