NEW PATIENT FORM

Ht:

Today's Date:

Wt:

***Welcome** to our practice! How can we make your child's experience as positive and comfortable as possible?*

1 TELL US ABOUT YOUR CHILD

Name: ______________________________
Last First Middle

Nickname: ____________________

Circle: (boy) (girl)

Birthdate: ____/____/______ Age: ________

SSN #: ________________

Home Address: ______________________________

City State Zip Code

Home #: (____) __________

Siblings (Name and Ages) treated here: ________________

School: ____________________ Grade: ________

Child's Interests/Hobbies/Activities: ________________

2 MOTHER'S INFORMATION

Name: ______________ Occupation: __________

Mother Stepmother Guardian Married Other: __________

Home Address: ______________________________

City State Zip Code

Employer: ______________________________

Home #: (____) ________ Work #: (____) ________

Cell #: (____) ________ Birthdate: ____/____/____

SSN: ________________ DL#: ______________

Email Address: ______________________________

Responsible for Account Payment: ☐ Yes ☐ No

3 FATHER'S INFORMATION

Name: ______________ Occupation: __________

Father Stepfather Guardian Married Other: __________

Home Address: ______________________________

City State Zip Code

Employer: ______________________________

Home #: (____) ________ Work #: (____) ________

Cell #: (____) ________ Birthdate: ____/____/____

SSN: ________________ DL#: ______________

Email Address: ______________________________

Responsible for Account Payment: ☐ Yes ☐ No

4 WHO MAY WE THANK FOR REFERRING YOU?

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: ______________________________

Relationship to child: ______________________________

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

6 PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

City State Zip Code

Insurance Co. Phone #: (____) ________________

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

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ____/____/______

SSN: ______________________________

Policy Owner's Employer: ______________________________

7 SECONDARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

City State Zip Code

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 Emergency Contact

Name: ______________ Relationship: __________

Home Address: ______________________________

Home #: (____) ________ Work #: (____) ________

Cell #: (____) ________

9 DENTAL - Child's Name: ______________

Reason for this appointment: ______________________________

Is this your child's 1st visit to the dentist? ☐ Yes ☐ No

If not, previous Office name: ______________ Last visit: ______

Any challenges associated with previous dental work? ☐ Yes ☐ No

If yes, please explain: ______________________________

Have there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No

If yes, please explain: ______________________________

How often per day child receives SUGARY foods/drinks: ____________________

Family history of dental concerns (ie missing or extra teeth, cavities)?

Please List: ____

Does the child CURRENTLY have any of the following habits?

- ☐ Pacifier
- ☐ Thumb/ Finger Sucking
- ☐ Nursing/ Bottle Feeding at night
- ☐ Mouth Breathing

Do you help your child brush & floss daily?	Yes	No
Does your child use fluoride supplements? (Drops, rinses, tablets, etc)	Yes	No
Is your child's water fluoridated?	Yes	No
Complications after dental treatment (EX: prolonged bleeding)?	Yes	No
Unusual reaction to dental medication or anesthetic?	Yes	No
Does your child wear a mouth guard for sports?	Yes	No

If yes to any of the above, please explain: ______________________________

____

10 CHILD'S MEDICAL HISTORY

Child's Physician's Name: ____

Physician's Address/ Phone #: ____________________________________

Please discuss any serious medical conditions your child has had:

____

____

Are your child's vaccinations up to date? ☐ Yes ☐ No

If no, please explain:____

Describe your pregnancy and delivery: ______________________________

1 - Is your child adopted? ☐ Yes ☐ No

2 - Has your child been hospitalized or had surgery? ☐ Yes ☐ No

3 - Has your child ever received General Anesthesia? ☐ Yes ☐ No

If yes, to 1-3 above please explain in detail here:

____

Please list all the foods and medications (drugs) your child is allergic to:

LIST allergies: ____

Please list all the medications your child is currently taking:

Name	Dose	Frequency

Circle ALL conditions your child HAS/HAD been treated for by physician:

NONE - No medical problems in the past or currently

ADD or ADHD	Hemophilia
AIDS or HIV	Hepatitis
Anemia	Infections (Viral or Bacterial)
Asthma/Reactive Airway	Jaundice
Arthritis/Rheumatic/Scarlet Fever	Kidney/Bladder Problems
Autism	Learning Disorders
Behavior/Emotional Problems	Liver Problems/ Biliary Atresia
Blood Disorders	Lung Problems/Cystic Fibrosis
Bleeding problems/Bruising	Pneumonia
Brain Injury	Pregnancy
Cancer (Chemo/Radiation)	Seizures/Epilepsy/Convulsions
Cerebral Palsy	Shunts (VP or VA)
Cleft Lip/Palate	Sickle Cell Anemia
Congenital Birth Defects	Sinus Problems
Defects/Genetic Disorders	Skin Problems/Eczema
Developmental Delays	Sleep Problems
Diabetes	Special Needs/Handicaps
Ears/Hearing Impairment	Speech Problems/Delay
Eyes/Vision Problems	Thyroid Problems
GI Problems/Reflux	Tonsil/Adenoid Problems
Headaches/Migraines	Transfusions
Heart Murmur/Disease	Transplants
Heart Disease	Tuberculosis

Describe checked items:

Authorization and Release Consent - This consent is to remain in effect until cancelled in writing

- **I understand that the information I have provided is accurate to the best of my knowledge and that it will be held in confidence.**
- **I understand that it is my responsibility to inform my dentist of any changes in my child's medical and/or dental health status, and I agree to do so.**
- **I give permission to the dentist and staff to obtain additional information from my child's physician(s) regarding any medical history needed to provide dental treatment.**
- **I authorize Midlothian Children's Dentistry (MCD) and Dr. Patel to release any information for my child during the period of such dental care to the third party payor's and/or health practitioners.**
- **I authorize my insurance co. to pay MCD and Dr. Patel all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions.**
- **I understand that I am responsible for all charges for services rendered whether or not it is covered by my insurance and that all payments are due on the day services are rendered.**

____

Signature of parent or Legal Guardian **Date** **Relationship to Patient (child)**

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