



NEW PATIENT FORM

Ht:

Today's Date:

Wt:

Welcome to Smile Garden Pediatric Dentistry!

1 TELL US ABOUT YOUR CHILD

Name: _____
Last First Middle

Nickname: _____ Circle: Male / Female

Birthdate: ____/____/____ Age: _____

SSN #: _____

Home Address: _____

City State Zip Code

Home #: (_____) _____

School: _____ Grade: _____

Child's Interests/Hobbies/Activities: _____

Siblings (Name and Ages) treated here: _____

2 LEGAL GUARDIAN #1 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 LEGAL GUARDIAN #2 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 first visit to the dentist? Yes No

If not, previous Dentist: _____ City: _____ 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 consumes SUGARY foods/drinks: _____

Family history of dental concerns (i.e. 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? Yes No
(Drops, rinses, tablets, etc)

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:

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 Smile Garden Pediatric Dentistry 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 company to pay Smile Garden Pediatric Dentistry 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

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

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 ever been treated for by a physician:

NONE - No medical problems currently or in the past

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: