



# 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 at Midlothian Children's 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 co. to pay MCD 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: