New Patient Form

Today's Date: _____

dr.lisa PEDIATRIC DENTISTRY

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

1 TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____

Child's Home #: (____)_____

Child's Home Address: _____

_____
City State Zip

2 PARENT 1 INFORMATION

Name: _____

Mother/Father Stepmother/Stepfather Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

3 PARENT 2 INFORMATION

Name: _____

Mother/Father Stepmother/Stepfather Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

4 WHO MAY WE THANK FOR REFERRING YOU?

_____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ YES ☐ NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

Email Address: _____

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____)_____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

9 DENTAL HISTORY

Child's Name _____

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

_____

_____

Why did you bring your child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y	N	Lip Sucking/Biting	Y	N	Nail Biting
Y	N	Nursing/Bottle Habits	Y	N	Thumb/Finger Sucking

Has the child ever had a serious or difficult problem associated with the previous dental work? **Yes** **No**

If yes, please explain: _____

_____

Is the child's water fluoridated **Yes** **No**

Is the child taking fluoride supplements? **Yes** **No**

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD) **Yes** **No**

Does the child brush his/her teeth daily? **Yes** **No**

Floss his/her teeth daily? **Yes** **No**

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y	N	Abnormal Bleeding	Y	N	ADD/ADHD
Y	N	Allergies to any Drugs	Y	N	Handicaps/Disabilities
Y	N	Allergies to Food	Y	N	Hearing Impairment
Y	N	Allergies to Food Dyes	Y	N	Heart Disease/Murmur
Y	N	Any Hospital Stays	Y	N	Hepatitis
Y	N	Any Operations	Y	N	HIV + AIDS
Y	N	Asthma	Y	N	Kidney/Liver Conditions
Y	N	Cancer	Y	N	Rheumatic/Scarlet Fever
Y	N	Congenital Birth Defects	Y	N	Allergies to Latex Product
Y	N	Convultions/Epilepsy	Y	N	Diabetes
Y	N	Pregnancy	Y	N	Hemophilia/Blood Disorders
Y	N	Tuberculosis	Y	N	Reflux/GI Problems

Please discuss any serious medical conditions the child has had:

_____

_____

Please list all the drugs the child is currently taking: _____

_____

Please list all the drugs the child is allergic to: _____

_____

Child's Physician: _____

Phone #: (____) _____

Is the child currently under the care of a physician? **Yes** **No**

Please describe the child's current pysical health:

GOOD **FAIR** **POOR**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

Revision: 04/07/2021