

NEW PATIENT INFORMATION

Date _____ Patient Social Security # _____

First Name _____ Last Name _____

Name your child would like to be called _____

Age _____ Birthday _____ Male or Female _____

Home Address _____ Mailing Address _____

City _____ State _____ Zip _____

Neighborhood _____

Home Phone () _____ Cell Phone () _____

Email _____

School _____ Grade _____

Name and ages of other children _____

Mother _____ DOB _____ SS# _____

Mother's Employer _____ Phone _____

Father _____ DOB _____ SS# _____

Father's Employer _____ Phone _____

Who has legal custody of patient? _____

Person responsible for payment of account & driver's license # _____

Dental Insurance yes no Medicaid yes no

Whom may we thank for referring you to our office? _____

What is the reason for your child's dental visit? _____

HEALTH HISTORY

Yes No Is your child in good health? Name of child's physician _____

Yes No Has your child ever had a health problem? _____

Yes No Has your child ever been hospitalized? Please give reasons and dates _____

Yes No Is your child allergic to anything (antibiotic, food, etc)? _____

Yes No Is your child currently taking any medications? Please give medications and reason:

Please **circle** if your child has been treated for any of the following:

Heart disease	Bleeding/transfusions	Asthma	Liver disease
Anemia	Kidney disease	Seizures	Rheumatic fever
Hepatitis	Speech/hearing	Diabetes	Cleft lip/palate
HIV/AIDS	Cerebral Palsy	Other problems	

