Paul A. Smith D.M.D.

Child New Patient Form

We would like to welcome your child to our office.

Tell Us About Your Child:

Today's Date: _____/_____/_____

Child's Name: ____

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

Nickname: ______________________________ □ Male □ Female

School: ____________________________ Grade: ____________

Hobbies: ____

Child's Home #: (____)___________ SS#: __________________

Child's Home Address: ________________________________

____

General Information:

Who is accompanying the child today?

Name: ______________________ Relation: _________________

Do you have legal custody of this Child? □ Yes □ No

Other Siblings: ____

Previous / Present Dentist: _______________ Last visit: _______

Dentist's Phone #: (____)________________________________

Relative or Friend not living with you:

Name: _____________________ Phone: (____)_____________

Address: ____

Parent Information:

Person Responsible for Account: ________________________

□ Father □ Step Father □ Guardian

Name: ________________________ Birthdate: ____/____/_____

Address: (if different than Child's) Hm #: (____)__________

____

____

SS #: _____________________ DL #: ____________________

Wk #: (____)____________ Ext: ____ Cell: (____)___________

Email: ____

Employer: ____

Employer Address: ______________________________________

____

Insurance Co. Name: ___________________________________

Insurance Address: _____________________________________

____

Insurance Phone: (____)_________________________________

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

□ Mother □ Step Mother □ Guardian

Name: ________________________ Birthdate: ____/____/_____

Address: (if different than Child's) Hm #: (____)__________

____

____

SS #: _____________________ DL #: ____________________

Wk #: (____)____________ Ext: ____ Cell: (____)___________

Email: ____

Employer: ____

Employer Address: ______________________________________

____

Insurance Co. Name: ___________________________________

Insurance Address: _____________________________________

____

Insurance Phone: (____)_________________________________

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

Release:

I certify that my child is covered by _______________________ Insurance Co. and I will assign all benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of Parent or Guardian Date:

Dental History:

Why did you bring the child to the dentist today? ___________________

____

____

Has the child ever taken any diet pills such as Phen-Fen? □ Yes □ No

If so, when? ____

Is the child currently in pain? □ Yes □ No

Does the child require antibiotics before treatment? □ Yes □ No

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

Is the child's water fluoridated? □ Yes □ No

Is the child taking fluoridated supplements? □ Yes □ No

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

Does the child brush daily? □ Yes □ No

Does the child floss teeth daily? □ Yes □ No

Child's Physician: ____

Phone #: _____________________ Date of Last Visit: ___/___/______

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

Please indicate the child's current health: □ Good □ Fair □ Poor

List all prescription or over the counter drugs that the child is currently taking: ____

____

Aside from items listed, please list all drugs / things that the child is allergic to: ____

____

Latex: □ Yes □ No Metals / Nickel: □ Yes □ No Plastic: □ Yes □ No

HIPPA Compliance:

Our office is HIPPA Compliant.

I affirm that the information I have given in correct to the best of my knowledge. 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

Medical History Update:

Has there been any change in your child's health status since their last visit? □ Yes □ No If yes, please explain. ____________________

____

Parent Sig. ______________________________ Date: ___/___/_______

Dentist Sig. _____________________________ Date: ___/___/_______

Medical History:

Has the child ever experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur
Y	N	ADD / ADHD	Y	N	Hepatitis
Y	N	AIDS / HIV +	Y	N	High Blood Pres.
Y	N	Anemia	Y	N	Hives
Y	N	Any Hospital Stays / Operations	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pres.
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	M.Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetics
Y	N	Epilepsy	Y	N	Scarlet Fever
Y	N	Handicaps	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis TB
Y	N	Exposed to HIV, but Neg.	Y	N	Rheumatic Fever

Are the child's immunizations current? □ Yes □ No

Anything you would like to discuss with the doctor in private? □ Yes □ No

Please discuss any serious medical problems the child experiences/ed:

____

____

Does / did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Hab
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

For Office Use Only:

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

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Signature of Dentist Date

Dentist's Comments: ____________________________________

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