

NEW PATIENT MINOR CHILD FORM

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function and appearance. Our staff is dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for dental health.

DATE: _____

PATIENT NAME: _____ PREFER'S TO BE CALLED _____

ADDRESS _____ HOME PHONE _____

CITY/STATE/ZIP _____

BIRTH DATE: _____ SEX: M ___ F ___ SS# _____

SCHOOL _____ GRADE _____

PARENT INFORMATION:

FATHER'S NAME: _____ SS# _____

EMPLOYER _____ WORK PHONE _____

CELL PHONE _____

MOTHER'S NAME: _____ SS# _____

EMPLOYER _____ WORK PHONE _____

CELL PHONE _____

PERSON RESPONSIBLE FOR PAYMENT:

NAME: _____

ADDRESS: _____

We will gladly assist you in filing the claims for your primary insurance if provided with the necessary information and a copy of the insurance card.

NAME OF PERSON WHO HAS POLICY _____

SS# OF POLICY HOLDER _____ BIRTH DATE _____

NAME OF INSURANCE CO. _____ INS GROUP # _____

I understand that payment is expected on the day of each service. I realize I am also responsible for any remaining charges that my insurance company chooses not pay.

SIGNATURE _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

OTHER FAMILY MEMBERS SEEN IN OUR OFFICE? _____

DENTAL HEALTH QUESTIONS

UPDATED 3/08

When was your last dental visit? _____

Who was your previous dentist? _____

Do you have sensitive teeth? _____ If so, what to? _____

Do your gums bleed when you floss? _____

What would you like to change about the appearance of your smile? _____

Do you have any fears about visiting the dentist (pain, cost, previous bad experience, lack of time)? _____

On a scale of 1-10, how would you rate your dental health? (1 being poor-10 being excellent)? _____

Circle one:

1 2 3 4 5 6 7 8 9 10

MEDICAL HEALTH QUESTIONS

Physician _____ Date of last visit _____

Medications you are currently taking: _____

Allergies to Medications _____

Any Recent Illness? _____

Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Do you have a history of the following?

- AIDS
- Cortisone Treatments
- HIV positive
- Respiratory disease
- Anemia
- Diabetes
- Jaw Pain
- Rheumatic Fever
- Arthritis
- Epilepsy
- Kidney Disease
- Scarlet Fever
- Artificial Heart Valve
- Fainting
- Latex Allergy
- Seizures
- Artificial Joints
- Glaucoma
- Liver Disease
- Shortness of
- Breath
- Asthma
- Headaches
- Mitral Valve Prolapse
- Stroke
- Back Problems
- Heart Murmur
- Nervous Problems
- Swelling Feet/Ankle
- Blood Thinners
- Heart problem
- Pacemaker
- Thyroid Problem
- Cancer
- Describe _____
- Phen-fen or Diet pills
- Tobacco Habit
- Chemical Dependent
- Hemophilia
- Prolonged Bleeding
- Tuberculosis
- Chemotherapy
- Hepatitis
- Psychiatric Care
- Ulcer
- Circulatory Problems
- High Blood Pressure
- Radiation Treatment
- Venereal Disease

Other _____