# NEW PATIENT FORM

**PATIENT INFORMATION**

Child's Name_____

Nickname_____ Sex: □ M □ F

Date of Birth ____/____/_____

Address _____

City _____ State _____ Zip _____

**RESPONSIBLE PARTY INFORMATION**

Parent #1 (Full Name) _____

Occupation _____

Cell Phone _____

Work Phone _____

Home Phone _____

Email _____

Parent #2 (Full Name) _____

Occupation _____

Cell Phone _____

Work Phone _____

Home Phone _____

Email _____

Best method to confirm appointments_____

In case of emergency, contact (Name and Phone):

_____

Purpose of visit _____

Concerns? _____

Name & Ages of Siblings _____

_____

Who may we thank for referring you to us?

_____

A parent or legal guardian must be present on this first visit

**HEALTH HISTORY**

Child's Pediatrician _____

Date of last physical exam ____/_____/_____

Pediatrician's Phone _____

Pediatrician's Address_____

City_____ State _____ Zip _____

Is your child under a physician's care now? □ Yes □ No

If Yes, Reason _____

Immunizations up to date? □ Yes □ No

Current Medications? _____

_____

Medication Allergies? _____

_____

Other Allergies _____

Child have an allergic reaction to any of the following?

□ Latex □ Pollen □ Dust □ Eggs □ Soy

□ Other _____

**Has your child had a history/difficulty with any of the following?**

□ Visual Disorders
□ Hearing Disorders
□ Ear Infections
□ Sinus Problems
□ Tuberculosis
□ Respiratory Problems
□ Heart Murmur
□ Cardiac Problems
□ Liver Disease/Hepatitis
□ Kidney/Renal Disease
□ Intestinal Problems
□ Muscular Disorder
□ Coordination Problems
□ Blood Disorders
□ Prolonged Bleeding
□ Major/Minor Surgery
□ Hospitalizations
□ Diabetes
□ Thyroid Problems
□ Arthritis
□ Snoring
□ Anemia
□ Seizures
□ Fainting
□ Tumors/Cancer
□ Learning Disability
□ ADD/ADHD
□ Delayed Speech
□ Speech Disorder/Therapy
□ Sensory Issues
□ Special Needs
□ Genetic Disorder
□ Autism
□ Delayed Development
□ Brain Injury
□ Premature Birth
□ Immune Disorders
□ Depression/Anxiety
□ Eating Disorder
□ TMJ Problems
□ Asthma
Last Asthma Attack _____
□ Other_____

If yes to any, please explain _____

_____

_____

_____

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**DENTAL HISTORY**

Is this your child's first dental visit? □ Yes □ No

If No, Previous Dentist _____

Previous Dentist Phone _____

Date of Last Visit ____/_____/_____

Were any x-rays taken? □ Yes □ No

How was his/her experience?_____

Is the patient having any dental discomfort? □ Yes □ No

Has the child had any injuries to the mouth/ head? □ Yes □ No

If Yes, Please Describe _____

Does your child have any habits? (Check all that apply):

□ Thumb/Finger □ Pacifier □Lip Sucking □Nail Biting

□ Mouth Breathing □ Snoring □Teeth Grinding

Do any family members have any missing teeth? □ Yes □ No

History of decay? □ Yes □ No

If Yes to missing teeth or decay, explain _____

Is the patient being breast fed? □ Yes □ No

Is the patient using a bottle? □ Yes □ No

If Yes, Contents? _____

How often does your child brush his/her teeth? _____x /day

How often does your child floss? _____ x/day

With adult supervision? _____

Does your child use any supplemental fluoride? □ Yes □ No

If Yes, what type? (rinse/prescription gel)? _____

How do you think your child will react toward dental treatment?

_____

How may we help to make this visit a positive experience for your child? _____

_____

Is there anything else we should know about your child?

_____

_____

**INSURANCE INFORMATION**

Dental insurance coverage for your child? □ Yes □ No

**PRIMAY DENTAL INSURANCE**

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner Birthdate _____

Insurance Company _____

Insurance Co Address _____

City _____ State _____ Zip _____

Insurance Co Phone _____

Insurance ID Number _____

Group or Policy Number _____

**SECONDARY DENTAL INSURANCE**

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner Birthdate _____

Insurance Company _____

Insurance Co Address _____

City _____ State _____ Zip _____

Insurance Co Phone _____

Insurance ID Number _____

Group or Policy Number _____

**SIGNATURES**

I hereby consent to dental procedures and techniques which the dentist, Dr. Megan Chin, deems necessary for the treatment of the patient. I authorize the dentist to provide any information to the other doctors for purpose of consultation. I understand that, prior to any treatment, I will be advised about it by the dentist or hygienist, that I may ask questions concerning it, and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of this patient.

_____

PRINT NAME

_____

SIGNATURE DATE

_____

DENTIST SIGNATURE DATE