Dentistry for Health and Wellness

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NEW PATIENT INFORMATION

Patient Information

Patient Name: ______________ ______________ ______________ ______________ Date: ______________
Last First Middle Preferred Name

Gender: ◯ Male ◯ Female Birth Date: ______________

Phone (H): ______________ (Work): ______________ Ext: ________ Best time to call: ________

Address: ______________________________ Apt. Num: ______________

______________________________ ______________ ______________
City State Zip Code

Contact Email: ______________________________

Responsible Party Information

Parent/Guardian Name: ______________________________

Social Security #: ______________ Birth Date: ______________

Phone (H): ______________ (Work): ______________ Ext: ________ Best time to call: ________

Address, if different from above:

______________ ________ ________ ________ ________
Street Apt. Num City State Zip Code

Employer Name: ______________ Occupation: ______________

Address: ______________ ________ ________ ________ ________
Street Apt. Num City State Zip Code

Insurance Plan Name: ______________________________

Address: ______________ ________ ________ ________
Street City State Zip Code

Phone: ______________ Group #: ______________

continued...

Medical History

Name of physician: ____________ Phone/Address: ____________

Date of last visit? ____________ Reason? ____________

Is your child currently under the care of a physician? ◯ Yes ◯ No Reason? ____________

Describe your child's overall physical health: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Please list medication(s) currently taking: ____________

Has your child ever been hospitalized or under a physician's care in the last two years? ◯ Yes ◯ No

If so, why? ____________

For Females: Taking birth control pills? ◯ Yes ◯ No Pregnant? ◯ Yes ◯ No Due Date: ____________

Has your child had any of the following? Please check those that apply:

- ☐ Abnormal bleeding
- ☐ Allergies: ____________
- ☐ Anemia
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Birth Defect
- ☐ Bladder Problems
- ☐ Blood transfusions
- ☐ Bone Disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy-Seizures
- ☐ Hearing Trouble
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Learning Disabilities
- ☐ Liver Disease
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Tuberculosis
- ☐ Other ____________

Allergy/Adverse Reaction to:

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex Allergy
- ☐ Nitrous Oxide (Laughling Gas)
- ☐ Nickel Allergy
- ☐ Novocain/Xylocaine
- ☐ Penicillin Allergy
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Valium

Are there any other conditions we should know about?

Dental History

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

If No, Former Dentist ____________ Address: ____________ Phone: ____________

Date of Last Dental Visit: ____________ Date of last x-ray: ____________

Reason for this visit? ____________

Does your child brush daily? ◯ Yes ◯ No Floss? ◯ Yes ◯ No

Does an adult assist with brushing/flossing? ◯ Yes ◯ No

Does you child experience pain or discomfort in the jaw joint? ◯ Yes ◯ No

Has your child experienced a mouth or jaw injury? ◯ Yes ◯ No

Was your child bottle fed? ◯ Yes ◯ No If yes, how long? ______________________

Does your child have any speech problems? ◯ Yes ◯ No If yes, Are you seeing a speech therapist? ◯ Yes ◯ No

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ◯ Yes ◯ No

Is fluoride taken in any of the following forms? ☐ Water supply ☐ Vitamins ☐ Toothpaste ☐ Tablets ☐ Rinse/Gel

Other information about your child's dental health or previous treatment

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are any changes in my child's health status, I will inform the doctor at the next appointment without fail.

______________________________ ______________

Signature of parent or guardian Date: