NEW PATIENT FORM

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About Your Child

Child's Name____
Nickname____
Age______________________________ Gender__________________________ Date of Birth______________________________________
Address____
City______________________________ State_________________________ Zip Code ____
Home Phone ________________________________Cell Phone____
Grade Level________________________________ Patient's Hobbies/Pets ____
Sibling's Names____
Referred to Our Office By______________________________________ Social Media: ☐Facebook ☐Google ☐Magazine

Medical History

Family Physician's Name___________________ Address_______________________ Phone Number_______________________

- Is your child in good health? If no, explain____
- Does your child have any drug allergies? ☐Yes ☐No
  If yes, explain ____
- Is your child taking any medication this time? ☐Yes ☐No
  If yes, list____
- Has your child ever been hospitalized or treated in an emergency room for any particular trauma? ☐Yes ☐No
  When and for what reason? ____
- Has your child been diagnosed with emotional, mental or nervous disorders? ☐Yes ☐No
  if yes, please explain____
- Have your child's tonsils and/or adenoids been removed? ☐Yes ☐No
- Does your child breathe through the mouth? ☐Yes ☐No
  If yes, ☐seldom ☐often

Please indicate if your child has had any of the followings:

☐Latex allergy/sensitivity
☐Allergy to penicillin
☐Other drug allergy
☐Anemia
☐ Autism/Asperger's syndrome
☐Bleeding disorder
☐bone disorder
☐Diabetes
☐cleft palate
☐Asthma
☐Endocrine disorders
☐Epilepsy, seizures
☐Hyperactivity/ADD/ADHD
☐Tuberculosis
☐Intellectual disability
☐Liver problems or hepatitis
☐Malignancies or leukemia
☐Physical handicap
☐Positive for H.I.V.
☐Radiation treatment
☐Rheumatic fever
☐Heart ailment or murmur. Type, if know_________________
☐Bronchitis

Is the child under the care of a cardiologist or special physician for the problem?
If so, whom ______________________phone________________
Please comment on any problems that were checked in the above areas____

* FOR OFFICE USE ONLY Weight :_____________ BP:___________/__________ Pulse:_______Temp:________
Next visit:_______________ Time of exit:_____________ Dr. Reviewing Med HX_________________________

Dental History

☐Yes ☐No Is this your child's first visit to the dentist? If no, when was the last visit?
____

☐Yes ☐No Do you expect your child to be a cooperative patient? If no please explain.________________________________

☐Yes ☐No Do you have well water in your home?

☐Yes ☐No Does your child take fluoride tablets or vitamins with fluoride?

☐Yes ☐No Has your child had an injury to her/his mouth or face? If so, when? ________________________________

☐Yes ☐No Has your child had history of headache, pain, popping or clicking of jaws?

☐Yes ☐No Does your child sleep with a bottle?

☐Yes ☐No Does your child have a toothache?

Does your child have or has he or she had any of the following problems/ habits?

❏Thumb sucker **How long?** ________________Still Active ☐Yes ☐No

❏Finger Habit **How long?** ________________Still Active ☐Yes ☐No

❏Pacifier **How long?** ________________Still Active ☐Yes ☐No

How often does your child brush? ____

Is tooth brushing supervised? ☐Yes ☐No by whom? ____________________

Is dental floss used? ☐Yes ☐No

Responsible Party

Father's Full name ____

Adresss____

City ____________________________State_______________________________Zip____________________________________

SS#____Birthday____

Home Phone____ Cell phone ____

Business Phone ______________________________________Employer____

Occupation_____________________ Email Address____

Dental Insurance ☐Yes ☐No Insurance company_____________________ Group plan___________________________________

Mother's Full Name____

Address____

City_____________________________ State_________________________________ Zip _________________________________

SS#____Birthday____

Home Phone____ Cell phone ____

Business Phone ______________________________________Employer____

Occupation_____________________ Email Address____

Dental Insurance ☐Yes ☐No Insurance company_____________________ Group plan___________________________________

*FOR OFFICE USE ONLY

Patient name: _________________________

DOB: ______________________

Clinical Findings

Radiographic Findings:
____
____

Tactile decay with explorer:
____
____

Other findings:
____
____

Diagnosis: ☐Early Childhood Caries ☐ Severe Early Childhood Caries

☐Dental Caries ☐ No Dental Caries

☐Incipient Decay