New Child Patient

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We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can and bring with to your first appointment. If you have any questions we'll be glad to help you.

PATIENT INFORMATION

Name of Minor/Child _____ Sex ☐ M ☐ F
Last Name *First Name* *Initial*

Age _____ Birth date _____ Nickname _____ Hobbies _____

Home Address _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

Person Financially Responsible _____

Home Phone _____ Work Phone _____

Email _____ How were you referred to us? _____

INSURANCE

Father's/Guardian's Name _____

Home Address _____
Street *City* *State* *Zip*

Home Phone _____ Work Phone _____

Employer _____

Soc. Sec. # _____ Birth date _____

Do you have dental insurance coverage for the minor/child? ☐ Yes ☐ No

Plan Name _____

Address _____

Phone No. _____ Group # _____ Policy # _____

Mother's/Guardian's Name _____

Home Address _____
Street *City* *State* *Zip*

Home Phone _____ Work Phone _____

Employer _____

Soc. Sec. # _____ Birth date _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Address _____

Phone No. _____ Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No

Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Minor/Child's Dentist/Pedodontist _____ City/State _____ Phone _____

Date of last visit to a dentist _____ For what service? _____

Has the child complained about dental problems? ☐ Yes ☐ No

Does child brush teeth daily? ☐ Yes ☐ No

Does child use floss every day? ☐ Yes ☐ No

Is fluoride taken in any form? ☐ Yes ☐ No

Any injuries to mouth, teeth, head? ☐ Yes ☐ No

Any unhappy dental experiences? ☐ Yes ☐ No

Any habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ Yes ☐ No

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? ☐ Yes ☐ No

Ever been hospitalized? ☐ Yes ☐ No

Ever had surgery? ☐ Yes ☐ No

Is there excessive bleeding when cut? ☐ Yes ☐ No

Medications _____ Allergies _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK.

☐ AIDS/HIV	☐ Convulsions	☐ Heart Problems	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Sinus Problems
☐ Asthma	☐ Drug/Alcohol Abuse	☐ Kidney Disease	☐ Thyroid Disease
☐ Bladder Problems		☐ Liver Disease	☐ Tuberculosis
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Other
☐ Cerebral Palsy	☐ Fainting	☐ Mononucleosis	
☐ Chicken Pox	☐ Hearing Problems	☐ Mumps	

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that 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 for my minor/child.

Signature of Parent/Guardian _____ Date _____

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company(ies) and assign directly to Dr. Reynolds all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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/Guardian _____ Date _____

UPDATE

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No

If yes, please list _____

Signature of Parent/Guardian _____ Date _____

Signature of Dentist _____ Date _____