KIDS NEW PATIENT INFORMATION

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. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date _____ **Referred by** _____

Name of Minor/Child _____
Last Name First Name Middle Initial

Sex ❑M ❑F **Age**_____ **Social Security Number**_____ **Medicaid Number** _____

Birthdate _____ **Nickname**_____

Home Address _____
Street City State Zip

Mailing Address_____
Street City State Zip

Person financially responsible_____ **Home Phone**_____ **Work Phone**_____

MEDICAL HISTORY

Minor/Child's Physician_____ **Phone**_____

Date of last physical examination, Result_____

Is Minor/Child under care of a physician now? Yes / No
Is Minor/Child receiving any medication or drugs now? Yes / No, If yes, what_____

To the best of your knowledge, has this minor/child ever had or now has any of the following: (All "yes" answers require an explanation.)

Yes	No		Yes	No	
❑	❑	Heart trouble or heart murmurs	❑	❑	Blood disease
❑	❑	Mitral Valve Prolapse	❑	❑	Dizziness or fainting spells
❑	❑	Pain or pressure in chest	❑	❑	Anemia
❑	❑	Rheumatic fever or growing pains	❑	❑	Bleeding gums
❑	❑	Swollen or painful joints or feet	❑	❑	Abnormal (easy) bruising)
❑	❑	Soaking sweats or prolonged fever	❑	❑	Excess bleeding following a scratch, cut or tooth extraction
❑	❑	High or low blood pressure			
❑	❑	Shortness of breath			
❑	❑	Frequent nose bleeds	❑	❑	Arthritis or rheumatism
❑	❑	Problems associated with a stroke	❑	❑	Frequent fractures or dislocations
			❑	❑	A condition requiring cortisone therapy
❑	❑	Glad problem, goiter, or thyroid condition	❑	❑	Back or neck injuries
❑	❑	Diabetes (sugar or albumin in urine)	❑	❑	Knee or hip replacement
❑	❑	Dry or burning mouth			
❑	❑	Members of your family with diabetes	❑	❑	Ear, eye, nose or throat trouble
			❑	❑	Frequent headaches
❑	❑	Respiratory disease	❑	❑	Facial injuries or toothaches
❑	❑	Continuous stuffy nose			
❑	❑	Asthma, hay fever or allergies	❑	❑	Tumors, growths, cysts or cancers
❑	❑	Tuberculosis	❑	❑	Recent gain or loss of weight
❑	❑	Halitosis	❑	❑	A reaction to serums, drugs or medicines
❑	❑	Chronic cough, hoarseness, or sore throat or coughing up blood	❑	❑	Any reaction to penicillin, antibiotics or dental anesthetics
❑	❑	Tobacco, snuff or alcohol habit	❑	❑	Series of needles, shots or injections
			❑	❑	Major operations or hospitalizations
❑	❑	Stomach or intestinal trouble or rectal bleeding			
❑	❑	Frequent indigestion, diarrhea, or vomiting problems or increasing constipation	❑	❑	Pregnancy or menstrual problems
❑	❑	Appetite problem or difficulty in swallowing	❑	❑	Skin rash, hives, or other skin problems
❑	❑	Jaundice or Hepatitis (type)	❑	❑	Venereal disease or any other conditions we should be aware of
❑	❑	Liver trouble, gall bladder trouble or stones	❑	❑	Scarlet fever, pneumonia or any high fever disease
			❑	❑	Mumps, Measles, Chicken Pox Age
❑	❑	Nervous or mental disorder	❑	❑	AIDS, ARC, HTV, ANTI-HIV Age
❑	❑	Epilepsy or convulsions	❑	❑	Blood transfusions How many? Age
❑	❑	Neuritis, neuralgia or numbness	❑	❑	Herpes
❑	❑	Cerebral Palsy			
❑	❑	Kidney disease or a problem of frequent urination at night or difficulty in urination			
❑	❑	Swollen ankles or eyelids			

DENTAL HISTORY

Date of last visit to dentist _____ **For what service** _____

	Yes	No
Has child complained about dental problems? _____	❑	❑
Does child brush teeth daily? _____	❑	❑
Does child use floss everyday? _____	❑	❑
Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc. _____	❑	❑

PARENT/GUARDIAN INFORMATION

Father's/Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone_____ **Work Phone** _____

Social Security#_____ **Birthdate** _____

Employer_____

Do you have dental insurance coverage for minor/child? **Y / N**

EMERGENCY CONTACT

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

Name_____ **Relationship**_____

Name_____ **Relationship**_____

AUTHORIZATION

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**