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PEDIATRIC DENTISTRY

NEW PATIENT FORM

202.966.0045 | PediatricDentalDC.com

About Your Child

Child's Name _____

Name Child Prefers To Be Called _____

Age _____ Gender _____ Date of Birth _____

Address _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____ Patient's School District (county/city) _____

Grade Level _____ Patient's Hobbies/Pets _____

Other Children and Their Ages _____

Referred To Our Office By (We Wish To Thank Them) _____

Parent's Marital Status:

Married Divorced Separated Widowed Single

Medical History

Is your child presently under the care of your family physician for any medical reason? Yes No If yes, explain _____

Family Physician/Pediatrician's Name: _____

Address: _____

Phone Number: _____

• Is your child in good health? If no, explain _____ Yes No

• Is your child under the care of a physician for other than routine care? If yes, explain _____ Yes No

• Does your child have any drug allergies? If yes, explain _____ Yes No

• Is your child taking any medications at this time? If yes, list. _____ Yes No

• Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? _____ Yes No

• Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. _____ Yes No

• Have your child's tonsils and/or adenoids been removed? Yes No

• Does your child breathe through the mouth? If yes, Seldom Often Yes No

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

- | | |
|--|--|
| <input type="checkbox"/> Allergy to Penicillin | <input type="checkbox"/> Intellectual disability |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Latex allergy/sensitivity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver problems or hepatitis |
| <input type="checkbox"/> Autism/Asperger's Syndrome | <input type="checkbox"/> Malignancies or leukemia |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Other drug allergy |
| <input type="checkbox"/> Bone disorder | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Positive for H.I.V. |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Endocrine disorder | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Epilepsy, seizures | <input type="checkbox"/> Speech problem |
| <input type="checkbox"/> Hyperactivity/ADD/ADHD | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart ailment or murmur. Type, if known _____ | |

Is 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 _____

Do you consider your child to be:

- | | |
|------------------------------------|--|
| • Advanced in the learning process | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Progressing normally | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • A slow learner | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Dental History

Yes No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child? _____

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

Yes No Do you have well water at home?

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

Yes No Has your child bumped any teeth? If so, when? _____

Yes No Has your child had a history of headaches, pain, popping or clicking of the jaws?

Yes No Does your child still have a night time bottle?

Yes No Does your child have a toothache?

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

- | | | | |
|--|-----------------|--------------|--|
| <input type="checkbox"/> Thumb Sucking | How Long? _____ | Still Active | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Finger Habit | How Long? _____ | Still Active | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pacifier | How Long? _____ | Still Active | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Dental History

How often does your child brush? _____

Is toothbrushing supervised? Yes No

By whom? _____

Is dental floss used? Yes No

Does your child receive: Fluoride in vitamins

Fluoride tablets/drops Bottled water

Fluoridated water Well water

Nearest Relative/Friend

Name

Address

Apt

City

State

Zip

Phone

Relationship

In case you are not at home, what is your neighbor's

Name

Phone

Responsible Party

Father's Full Name

Address

Apt

City

State

Zip

SS#

Birthdate

Home Phone

Cell Phone

Business Phone

Employer

Occupation

Email Address

Mother's Full Name

Address

Apt

City

State

Zip

SS#

Birthdate

Home Phone

Cell Phone

Business Phone

Employer

Occupation

Email Address

Financial Information

Method of Payment:

Please check one:

Check or cash at time of treatment

Visa, Mastercard, American Express or Discover

Other: _____

• Payment is expected at time of treatment.

• All emergency patients (being seen for the first time) are required to pay in full at time of treatment.

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same.

I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED (parent or legal guardian)

DATE