CHILDS NEW PATIENT FORM

Name: _____Sex: _____Birthday: _____Age: _____
Address: _____City: _____St: ___Zip: _____
Account Number: _____ Home Phone: _____
School: _____

**********Parent/Guardian Information**********

Responsible Party Name: _____Date of Birth: _____Sex: _____
Address: _____City_____St_____ZIP_____
Mailing address if different: _____
How long at this address? _____ if less than 3 years, previous address: _____
SSN: _____ Marital Status_____ Employer: _____ How long? _____
Work Phone No: _____ Cell: _____ Email: _____
If using Pre-tax Medical Spending account please inform us prior to making financial arrangements.
Spouse: _____ Relation to patient: _____
Occupation: _____ Employer: _____ Work Phone: _____
Number of years with above: ____ SSN: _____ Date of Birth: _____
Cell: _____ Email: _____

How would you like to receive your appointment reminders? Text Email Home? (circle choice)

**********Medical History**********

Is patient in good health? Yes ___ No ___
Has patient ever sucked thumb/finger? Yes ___ No ___

- Until what age? _____

Does patient breathe through his mouth _____ or nose _____?
Has patient suffered trauma to the head and/or neck? _____ at that age:_____
Has patient been in a motor vehicle accident? _____ when? _____
If female, has patient started menses? _____ if so what age? _____
Have we treated any other members of your family? Yes No, Names: _____
If you would like to receive your appointment notices by text messages: please let us know
Has patient had any of the illnesses listed below? If so, please check ones that apply.

__Rheumatic Fever __Heart Valve Problems __Glaucoma __Anemia
__Diabetes __Bleeding Tendencies __Hepatitis __Cancer
__Mononucleosis __High Blood Pressure __Epilepsy __Asthma
__Allergies __Palpitations __Allergic Anesthetics
__Tuberculosis __Stomach Ulcers __Temporomandibular joint pain
__Tested positive HIV (AIDS)

Do you have pain in your face or jaw? Yes ___ No ___
Does your jaw make a noise? ie.. popping, clicking Yes ___ No ___
Does your jaw get stuck so you cannot open or close? Yes ___ No ___
Do you have a history of a major condition/illness? Yes ___ No ___
Please list: _____
Please list any drug sensitivities or allergies: _____
Please lists all medications the patient is taking: _____
Reason for visit: _____
Medical Doctor: _____ General Dentist: _____
Whom may we thank for referring you to our office? _____
Patient's interests/hobbies? _____

_____
(Parent/Guardian Signature) date: Dr Signature: