CHILD NEW PATIENT FORM

Name:____Sex:______Age:______Birthday:____________________

Address:____City:__________________St.____Zip_________

Phone #:_________________________________Email:____

School:____

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

Responsible Party Name:____Date of Birth:______________Sex_____

Address if different from above:

____City:__________________St.____Zip______

Employer:____________________________Occupation:__________________________Work #:________________

Marital Status:________Spouse:________________________________Relation to Patient:____________________

Employer:______________________________Occupation:________________________Work #:________________

Medical History

Is patient in good health? ___Yes ___No

Has patient ever sucked thumb/finger? ___Yes ___No If Yes until what age?______________

Does patient breathe through mouth _____or nose_____?

Has patient suffered trauma to the head and/or neck?________at what age:_______

Has patient been in a motor vehicle accident? __________when?____________________

If female, has patient started menses? _________if so at what age?__________

Have we treated any other members of your family? __Yes __No If yes,names:___________________________

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 to Anesthetics

___Tuberculosis ___Stomach Ulcers ___Temporomandibular joint pain

___Tested positive HIV (Aids)

Does your child have pain in the face or jaw? ___Yes ___No

Does your child's jaw make a noise? –popping, or clicking ___Yes ___No

Does your child's jaw get stuck so they can't open or close? ___Yes ___No

Does your child have a history of a major condition/illness ___Yes ___No

Please list any conditions/illness____

Please list any drug sensitivities or allergies____

Please list any medications the patient is taking____

Is your child presently taking Advil, Motrin or Tylenol on a daily basis? ___ Yes ___No

Medical Doctor:___________________________________General Dentist:_________________________

Reason for visit:____

Whom may we thank for referring you to our office?____

Patients interests/hobbies?____

Parents/Guardian Signature:____Date:_______________

Drs Signature:

Updated on:

____

____