New Patient Form

Today's Date:

pediatric Dentistry, Ltd.
3142 49th Street South, Fargo, ND 58104
Ph: 701-293-6999 | Fax: 701-235-2297

1 TELL US ABOUT YOUR CHILD

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: _____ Child's Age: _____

School: _____

Siblings We Treat: _____

Child's Home Address: _____

_____

City State Zip

Child's Home #: _____

Special Interests: _____

2 DENTAL HISTORY

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name: _____

Date of Last X-Rays at Previous Dental Visits: _____

Have there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Why did you bring your child to the dentist today?

_____

_____

_____

Does your child have any of the following habits?

- ☐ Lip Sucking / Biting
- ☐ Nail Biting
- ☐ Nursing / Bottle Habits
- ☐ Thumb / Finger Sucking
- ☐ Tobacco Use

Does your child have any current dental issues?

- ☐ Cavities
- ☐ Toothache
- ☐ Bleeding Gums
- ☐ Discolored Teeth
- ☐ Bad Breath
- ☐ Teeth Grinding
- ☐ Mouth Trauma/Broken Tooth
- ☐ Sensitivity to Hot/Cold

Has your child ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Is your child's water fluoridated? ☐ Yes ☐ No

Is your child taking fluoride supplements? ☐ Yes ☐ No

Has your child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No

3 SOCIAL HISTORY

Child's First Language: _____

Child's Second Language: _____

4 HEALTH HISTORY

Has your child ever had any of the following conditions?

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Allergies to Any Drugs
- ☐ Allergies to Latex Products
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Cancer
- ☐ Cardiac (Heart Conditions)
- ☐ Congenital Birth Defects
- ☐ Developmental Delays/ Disabilities
- ☐ Diabetes
- ☐ Hearing Impairment
- ☐ Hemophilia/Blood Disorders
- ☐ Hepatitis
- ☐ HIV + / AIDS
- ☐ Kidney/Liver Conditions
- ☐ Pregnancy
- ☐ Reflux/GI Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Tuberculosis
- ☐ None of the Above

If you checked any of the above conditions, or if you would like to discuss any other medical conditions your child has had, do so below:

_____

_____

List all drugs your child is currently taking.

_____

List all allergies your child currently has.

_____

Child's Physician: _____

Phone #: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

5 PARENT OR LEGAL GUARDIAN'S INFORMATION

The information in this section applies to the main legal caregiver of the child / children.

Name: _____

Relationship: _____ Birthdate: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

_____

City State Zip

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

SSN: _____ DL#: _____

Email Address: _____

6 SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION

(If different from #2 above.)

Name: _____

Relationship: _____ Birthdate: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

_____

City State Zip

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

SSN: _____ DL#: _____

Email Address: _____

7 HOW DID YOU LEARN ABOUT OUR PRACTICE

_____

8 WHO WILL BE ACCOMPANYING THE CHILD/CHILDREN TO THEIR APPOINTMENT?

Important Note: The parent or guardian who accompanies the child is legally responsible for payment at the time of service.

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

9 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____

City State Zip

Work #: _____

Home #: _____

Cell #: _____

Email Address: _____

10 PRIMARY DENTAL INSURANCE

Insurance Name: _____

Insurance Address: _____

_____

City State Zip

Insurance Phone: _____

Group #: _____

Policy Owner's Name: _____

Relationship: _____

Birthdate: _____

SSN: _____

Employer: _____

11 DUAL (SECONDARY) INSURANCE

Do you have dual (secondary) insurance? ☐ Yes ☐ No Insurance Name: _____

12 SIGNATURE

I understand that the information I have given is correct to the best of my knowledge and that 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 my child may need.

_____ _____

Signature of Parent or Guardian Relationship to Patient

_____

Date

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____