NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name _____ ☐ Male ☐ Female
LAST FIRST MI

Address _____
STREET CITY STATE ZIP

Birth Date _____ Social Security No. _____ Home Phone _____

E-Mail Address _____ Cell Phone _____

If full-time student, name school _____ Grade _____

Number of children in family _____ Have we ever seen any of your children in our office? _____

Names of children: _____

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

Why did you bring your child to the dentist today? _____

FAMILY INFORMATION

FATHER	
LAST	FIRST
STREET	CITY / STATE / ZIP
HOME #	CELL #
DATE OF BIRTH	SOCIAL SECURITY NUMBER
EMPLOYER	
DENTAL INSURANCE CO	GROUP #

MOTHER	
LAST	FIRST
STREET	CITY / STATE / ZIP
HOME #	CELL #
DATE OF BIRTH	SOCIAL SECURITY NUMBER
EMPLOYER	
DENTAL INSURANCE CO	GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

☐ Mother ☐ Father ☐ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF AN EMERGENCY

Name: _____ Phone: _____

Address: _____

AUTHORIZATION

I hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers payers and/or other health professionals.

Signature of Responsible Party: _____ Date: _____

☐ Mother ☐ Father ☐ Guardian ☐ Other (relationship)_____

OVER →

HEALTH HISTORY

Has your child ever been to the dentist? Yes No

Date of Last Visit? _____

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

Is your water fluoridated? Yes No

Is your child taking a fluoride supplement? Yes No

Has your child ever had an injury to the face, mouth, or teeth? Yes No

Has your child ever had:

- Tooth Aches? Yes No
- Bleeding Gums? Yes No
- Missing Teeth? Yes No

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

Does your child floss daily? Yes No

Child's Pediatrician: _____

Phone # _____ Date of Treatment: _____

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

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

Please list all drugs that your child is allergic to:

Is your child allergic to latex gloves? _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Thumb/Finger Sucking	☐	Grinding/Clenching	☐
Lip Sucking/Biting	☐	Mouth Breathing	☐
Nail Biting	☐	Tongue Thrust	☐
Cheek Biting	☐	Tongue Tied	☐
Nursing Bottle Habit	☐	Pacifier Habit	☐

Doctor's Comments: _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING PROBLEMS:

Heart Problems	☐	Fainting/Dizziness	☐
Heart Murmur	☐	Nervous Disorder	☐
Rheumatic Fever	☐	Brain Injury	☐
Bleeding Disorder	☐	Learning Disability	☐
AIDS/HIV+	☐	Emotional Problems	☐
Hemophilia	☐	Bone Disorders	☐
Hepatitis A or B	☐	Sore Throats	☐
Diabetes	☐	Ear Aches	☐
Kidney Problems	☐	Hearing Loss	☐
Liver Problems	☐	Speech Problems	☐
Epilepsy	☐	Eye Disorders	☐
Seizures	☐	Measles	☐
Cerebral Palsy	☐	Mumps	☐
Tuberculosis	☐	Chicken Pox	☐
Anemia	☐	Allergies	☐
Asthma	☐	Sinusitis	☐
Endocrine Problems	☐	Tonsillitis	☐
Autism	☐	Mental Retardation	☐
Downs Syndrome	☐		

Please discuss any serious medical problems that your child has had: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA, including the heat autoclave sterilization of handpieces.

AUTHORIZATION

I understand that the information given is correct to the best of my knowledge, that it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature: _____ Date: _____

OFFICE USE ONLY OFFICE USE ONLY

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

Initial: _____ Date: _____