

## Child & Adolescence – New Patient Paperwork

Subscriber's Social Security #:       Subscriber's Employer:         Secondary Dental Insurance Co. Name:       Insurance Co. Name:         Policy #:       Group #:       Plan #:         Subscriber's Name:       Relationship to Patient:       Subscriber's DOB:         Subscriber's Social Security #:       Subscriber's Employer:       Subscriber's DOB:         Dental History       Relationship to Patient:       Subscriber's DOB:         Mass done at last visit?       Is the child currently in pain:       Yes         What was done at last visit?       Last Cleaning:       How often do you brush:       Yes         Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?       Yes       No       If yes, explain       Yes         Is the child superienced problems with previous dental work?       Yes       No       Is the child taking fluoridated supplements?       Yes       No         Does the child brush his/her teeth daily?       Yes       No       Does an adult assist with brushing?       Yes       No         Previous/Present Dentist:	Patient Information			Today's Date:				
Address:	Patient Name:							
Address:	Home #: Ce	#:	Email (Appt. Con	firmations):				
HOW DID YOU HEAR ABOUT US?         Responsible Party Information         Person Responsible for Accountmust be parent/legal guardian who created the account with the practice and who completes the paperwork:         First Name:								
Person Responsible for Account – must be parent/legal guardian who created the account with the practice and who completes the paperwork:         First Name:								
First Name:		. //						
SS#:Occupation:Employer:Work #: Insurance Information Primary Dental Insurance Insurance Co. Name: Insurance Co. Phone #: Subscriber's Name: Relationship to Patient: Subscriber's DOB: Subscriber's Social Security #: Subscriber's Employer: Secondary Dental Insurance Insurance Co. Name: Insurance Co. Phone #: Subscriber's Social Security #: Subscriber's Employer: Subscriber's Name: Relationship to Patient: Subscriber's DOB: Subscriber's Name: Relationship to Patient: Subscriber's DOB: Subscriber's Social Security #: Subscriber's Employer: Dental History Reason for today's visit: Is the child currently in pain: □ Yes What was done at last visit? Last Cleaning: Is the child currently in pain: □ Yes What was done at last visit? Last Cleaning: How often do you brush: Has the child ever had any injuries to his/her teeth, mouth, head or jaws? □ Yes □ No Has the child ever had any injuries to his/her teeth, mouth, head or jaws? □ Yes □ No Is the child swater fluoridated? □ □ Yes □ No Is the child swater fluoridated? □ □ Yes □ No Does an adult assist with brushing? □ Yes □ No Previous/Present Dentist: Date of last visit: Y N Lip Sucking/Bitting Y N Clenching/Grinding Teeth Y N Tongue/Cheek Bitting Y N Nail Bitting Y N Used Pacifier - until age Y N Speech Problems Y N Nail Bitting Y N Lip All Pacifier - until age Y N Still in Sippy Cup Medical History Child's Physician's: Phone#: Date of last visit #: Address:								
Insurance Information         Primary Dental Insurance         Insurance Co. Name:       Insurance Co. Phone #:         Policy #:       Group #:       Plan #:         Subscriber's Name:       Relationship to Patient:       Subscriber's DOB:         Subscriber's Social Security #:       Subscriber's Employer:       Subscriber's DOB:         Secondary Dental Insurance       Insurance Co. Phone #:								
Primary Dental Insurance       Insurance Co. Name:	SS#: Occupation:		Employer:	Work #:				
Insurance Co. Name: Insurance Co. Phone #:   Policy #: Group #:   Plan #:   Subscriber's Name:   Subscriber's Social Security #:   Subscriber's Social Security #:   Subscriber's Social Security #:   Subscriber's Co. Name:   Policy #:   Group #:   Policy #:   Group #:   Policy #:   Group #:   Policy #:   Group #:   Plan #:   Subscriber's DOB:   Subscriber's Name:   Subscriber's Social Security #:   Subscriber's Subscriber's DOB:   Subscriber's Subscriber's Subscriber's DOB:   Subscriber's Subscriber's Subscriber's DOB:   Has the child ever had any pain/tenderness i								
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Subscriber's Name:								
Subscriber's Social Security #:Subscriber's Employer: Secondary Dental Insurance Insurance Co. Name: Insurance Co. Phone #: Policy #: Group #: Plan #: Subscriber's Name: Relationship to Patient: Subscriber's DOB: Subscriber's Social Security #: Subscriber's Employer: Dental History Reason for today's visit: Is the child currently in pain: □ Yes What was done at last visit? Last Cleaning: How often do you brush: Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No Has the child ever had any najin/reis to his/her teeth, mouth, head or jaws? □ Yes □ No Has the child ever had any injuries to his/her teeth, mouth, head or jaws? □ Yes □ No Has the child ever had any injuries to his/her teeth, mouth, head or jaws? □ Yes □ No Is the child taking fluoridated supplements? □ Yes □ No Does the child is water fluoridated? □ Yes □ No Does an adult assist with brushing? □ Yes □ No Previous/Present Dentist: Date of last visit: Y N Lip Sucking/Biting Y N Clenching/Grinding Teeth Y N Tongue/Cheek Biting Y N Nail Biting Y N Used Pacifier - until age Y N Speech Problems Y N Chewing on Objects Y N Nursing/Bottle Habits - until age Y N Still in Sippy Cup Medical History Child's Physician's: Phone#: Date of last visit #: Address:								
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Insurance Co. Name:	Subscriber's Social Security #:		Subscriber's Employer: _					
Policy #: Group #: Plan #:         Subscriber's Name: Relationship to Patient: Subscriber's DOB:         Subscriber's Social Security #: Subscriber's Employer:         Dental History         Reason for today's visit: Is the child currently in pain: □ Yes         What was done at last visit? Last Cleaning: How often do you brush:         Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No         Has the child experienced problems with previous dental work? □ Yes □ No         Has the child experienced problems with previous dental work? □ Yes □ No         Is the child brush his/her teeth daily? □ Yes □ No         Is the child brush his/her teeth daily? □ Yes □ No         Does the child brush his/her teeth daily? □ Yes □ No         Does the child brush his/her teeth daily? □ Yes □ No         Does of the following habits?         Y N       Clenching/Grinding Teeth Y N         Y N       Clenching/Grinding Teeth Y N         Y N       N Used Pacifier - until age Y N         Y N       N Nursing/Bottle Habits - until age Y N         Y N       N Nursing/Bottle Habits - until age Y N         Y N       N Nursing/Bottle Habits - until age Y N         Y N       N Nursing/Bottle Habits - until age Y N         Y N	· · · · · · · · · · · · · · · · · · ·		Insurance Co.	Phone #:				
Subscriber's Name:       Relationship to Patient:       Subscriber's DOB:         Subscriber's Social Security #:       Subscriber's Employer:         Dental History         Reason for today's visit:       Is the child currently in pain:         Yes         What was done at last visit?       Last Cleaning:         How often do you brush:         Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?       Yes         Nas the child ever had any nain/tenderness in his/her jaw joint (TMJ/TMD)?       Yes         Has the child ever had any nain/tenderness in his/her jaw joint (TMJ/TMD)?       Yes         Nas the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?       Yes         Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?       Yes         Nas the child scaperienced problems with previous dental work?       Yes         Is the child taking fluoridated?       Yes         No       Is the child taking fluoridated supplements?         Yes       No       Does an adult assist with brushing?         Previous/Present Dentist:								
Subscriber's Social Security #:       Subscriber's Employer:         Dental History         Reason for today's visit:       Is the child currently in pain: □ Yes         What was done at last visit?       Last Cleaning:       How often do you brush:         Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?       PYes □ No       Has the child ever had any injuries to his/her teeth, mouth, head or jaws?       PYes □ No         Has the child ever had any injuries to his/her teeth, mouth, head or jaws?       □ Yes □ No       If yes, explain         Has the child brush his/her teeth and work?       □ Yes □ No       If yes, explain         Is the child brush his/her teeth daily?       □ Yes □ No       Is the child taking fluoridated supplements?       □ Yes □ No         Does the child brush his/her teeth daily?       □ Yes □ No       □ Does an adult assist with brushing?       □ Yes □ No         Previous/Present Dentist:								
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Does the child brush his/her teeth daily?       Yes No       Does an adult assist with brushing?       Yes No         Previous/Present Dentist:	Has the child experienced problems wit	h previous d	ental work?	If yes, explain				
Previous/Present Dentist:	Is the child's water fluoridated?	🗆 Yes 🗆	No Is the child	taking fluoridated supplements?				
Y       N       Lip Sucking/Biting       Y       N       Clenching/Grinding Teeth       Y       N       Tongue/Cheek Biting         Y       N       Nail Biting       Y       N       Used Pacifier – until age       Y       N       Speech Problems         Y       N       Chewing on Objects       Y       N       Nursing/Bottle Habits – until age       Y       N       Tongue Thrust         Y       N       Mouth Breather       Y       N       Thumb/Finger Sucking – until age       Y       N       Still in Sippy Cup         Medical History         Child's Physician's:        Phone#:        Date of last visit #:          Address:        City       State       Zip				_				
Y       N       Lip Sucking/Biting       Y       N       Clenching/Grinding Teeth       Y       N       Tongue/Cheek Biting         Y       N       Nail Biting       Y       N       Used Pacifier – until age       Y       N       Speech Problems         Y       N       Chewing on Objects       Y       N       Nursing/Bottle Habits – until age       Y       N       Tongue Thrust         Y       N       Mouth Breather       Y       N       Thumb/Finger Sucking – until age       Y       N       Still in Sippy Cup         Medical History       Child's Physician's:       Phone#:       Date of last visit #:         Address:       Street       City       State       Zip	Previous/Present Dentist:			Date of last visit:				
Y N Nail Biting       Y N Used Pacifier – until age       Y N Speech Problems         Y N Chewing on Objects       Y N Nursing/Bottle Habits – until age       Y N Tongue Thrust         Y N Mouth Breather       Y N Thumb/Finger Sucking – until age       Y N Still in Sippy Cup         Medical History       Child's Physician's:       Phone#:       Date of last visit #:         Address:       Street       City       State       Zip		Does/dio	l your child have any of the following l	habits?				
Y       N       Nail Biting       Y       N       Used Pacifier – until age       Y       N       Speech Problems         Y       N       Chewing on Objects       Y       N       Nursing/Bottle Habits – until age       Y       N       Tongue Thrust         Y       N       Mouth Breather       Y       N       Thumb/Finger Sucking – until age       Y       N       Still in Sippy Cup         Medical History       Child's Physician's:       Phone#:       Date of last visit #:         Address:       Street       City       State       Zip	Y N Lip Sucking/Biting	YNO	Clenching/Grinding Teeth	Y N Tongue/Cheek Biting				
Y N Chewing on Objects       Y N Nursing/Bottle Habits – until age       Y N Tongue Thrust         Y N Mouth Breather       Y N Thumb/Finger Sucking – until age       Y N Still in Sippy Cup         Medical History       Child's Physician's:       Phone#:       Date of last visit #:         Address:       Street       City       State       Zip		YNU	Jsed Pacifier – until age					
Y N Mouth Breather       Y N Thumb/Finger Sucking – until age       Y N Still in Sippy Cup         Medical History       Phone#:       Date of last visit #:         Child's Physician's:       Phone#:       Date of last visit #:         Address:       Street       City       State       Zip	Y N Chewing on Objects			Y N Tongue Thrust				
Child's Physician's:        Phone#:        Date of last visit #:          Address:         City       State       Zip	Y N Mouth Breather			Y N Still in Sippy Cup				
Child's Physician's:        Phone#:        Date of last visit #:          Address:              Street       City       State       Zip	Medical History							
Address:			Phone#:	Date of last visit #:				
Street City State Zip								
is the child currently under the care of a physician? $\Box$ Yes $\Box$ No - it yes Explain.	Street		City	State Zip				
Please describe the child's current physical health? Good Fair Poor Are immunizations current? Yes No								

Ple	ase l	ist all drugs that the child is curre	ently ta	king	:			
Ple	ase l	ist all drugs that cause the child	allergic	read	tions:			
An	ythir	ng you would like to discuss with	n the do	octor	· in private? Y N If yes, Explain	:		
					child had/experienced any of the followi			
Y	Ν	Abnormal Bleeding	Y	Ν	Cerebral Palsy	Y	Ν	Lupus
Y	Ν	Acid Reflux	Y	Ν	Chemotherapy / Radiation Treatment	Y	Ν	Measles
Y	Ν	ADHD	Y	Ν	Developmental Delay	Y	Ν	Mononucleosis (MONO)
Y	Ν	Aids/HIV+	Y	Ν	Diabetes: Type	Y	Ν	Mouth Sores
Y	Ν	Anaphylactic Reaction	Y	Ν	Epilepsy / Seizures	Y	Ν	Rheumatic Fever
Y	Ν	Anemia	Y	Ν	Hearing Impairments	Y	Ν	Scarlet Fever
Y	Ν	Asthma	Y	Ν	Hemophilia: Type	Y	Ν	Sickle Cell Anemia
Y	Ν	Autism/Related Disorder	Y	Ν	Hepatitis: Type	Y	Ν	Tonsillitis
Y	Ν	ANY HEART CONDITION**	Y	Ν	High Blood Pressure	Y	Ν	Tuberculosis (TB)
Y	Ν	Cancer	Y	Ν	Kidney Problems	Y	Ν	Premed Needed-Cleaning
Y	Ν	Cleft Palate / Lip	Y	Ν	Liver Problems			
Сн	ЕСК /	ANY OF THE FOLLOWING THAT HAV	E CAUSE		LERGIES/ADVERSE REACTIONS:			
	Peni	cillin 🗆 Tetracycline 🗆 Er	YTHROM	IYCIN	Sulfa Codeine Valium	BARBITUR	ATES	🗆 LATEX 🗆 RED DYE
	Aspi	RIN 🗆 LOCAL ANESTHETICS		ND/	Advil/Motrin 🛛 Other, Please Explain:			
FEI		PATIENTS:						
				<b>D</b> -				
AR	E YOU	PREGNANT NOW?  VES  NO		PR.	ACTICING BIRTH CONTROL?  VES  NO			
An	y me	dical history not listed above? P	lease e	kplai	n:			
**	fanv	heart condition, please specify	here. If	anv	medical history not listed above? Please e	explain:		
				'	,	•		

## **Authorization**

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. It is also my responsibility to inform this office of any changes in my insurance coverage. I understand that payment is due at the time services are rendered.

Responsible Party's Signature

Please Print Responsible Party's Name

Date