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PEDIATRIC DENTISTRY .....

# NEW PATIENT FORM

202.966.0045 | [PediatricDentalDC.com](http://PediatricDentalDC.com)

## About Your Child

Child's Name \_\_\_\_\_

Name Child Prefers To Be Called \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Patient's School District (county/city) \_\_\_\_\_

Grade Level \_\_\_\_\_ Patient's Hobbies/Pets \_\_\_\_\_

Other Children and Their Ages \_\_\_\_\_

Referred To Our Office By (We Wish To Thank Them) \_\_\_\_\_

Parent's Marital Status:  
 Married  Divorced  Separated  Widowed  Single

## Dental History

Yes  No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child?  
\_\_\_\_\_

Yes  No Do you expect your child to be a cooperative patient? If no, please explain.  
\_\_\_\_\_

Yes  No Do you have well water at home?

Yes  No Does your child take fluoride tablets or vitamins with fluoride?

Yes  No Has your child bumped any teeth? If so, when?  
\_\_\_\_\_

Yes  No Has your child had a history of headaches, pain, popping or clicking of the jaws?

Yes  No Does your child still have a night time bottle?

Yes  No Does your child have a toothache?

**Does your child have or has he or she had any of the following problems or habits?**

Thumb Sucking How Long? \_\_\_\_\_ Still Active  Yes  No

Finger Habit How Long? \_\_\_\_\_ Still Active  Yes  No

Pacifier How Long? \_\_\_\_\_ Still Active  Yes  No

## Medical History

Is your child presently under the care of your family physician for any medical reason?  Yes  No If yes, explain \_\_\_\_\_

Family Physician/ Pediatrician 's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

- Is your child in good health? If no, explain \_\_\_\_\_  Yes  No
- Is your child under the care of a physician for other than routine care? If yes, explain \_\_\_\_\_  Yes  No
- Does your child have any drug allergies? If yes, explain \_\_\_\_\_  Yes  No
- Is your child taking any medications at this time? If yes, list. \_\_\_\_\_  Yes  No
- Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? \_\_\_\_\_  Yes  No
- Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. \_\_\_\_\_  Yes  No
- Have your child's tonsils and/or adenoids been removed?  Yes  No
- Does your child breathe through the mouth? If yes,  Seldom  Often  Yes  No

**Please indicate if your child has had any of the following:**

- Allergy to Penicillin
- Anemia
- Asthma
- Autism/Asperger's Syndrome
- Bleeding disorder
- Bone disorder
- Cleft palate
- Diabetes
- Endocrine disorder
- Epilepsy, seizures
- Hyperactivity/ADD/ADHD
- Heart ailment or murmur. Type, if known \_\_\_\_\_
- Intellectual disability
- Latex allergy/sensitivity
- Liver problems or hepatitis
- Malignancies or leukemia
- Other drug allergy
- Physical handicap
- Positive for H.I.V.
- Radiation treatment
- Rheumatic fever
- Speech problem
- Tuberculosis

Is child under the care of a cardiologist or special physician for the problem? If so, whom \_\_\_\_\_  
Phone \_\_\_\_\_

Please comment on any problems that were checked in the above areas \_\_\_\_\_

**Do you consider your child to be:**

- Advanced in the learning process  Yes  No
- Progressing normally  Yes  No
- A slow learner  Yes  No

## Dental History

How often does your child brush? \_\_\_\_\_

Is toothbrushing supervised?  Yes  No

By whom? \_\_\_\_\_

Is dental floss used?  Yes  No

Does your child receive:  Fluoride in vitamins

Fluoride tablets/drops  Bottled water

Fluoridated water  Well water

## Responsible Party

\_\_\_\_\_  
Father's Full Name

\_\_\_\_\_  
Address Apt

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
SS# Birthdate

\_\_\_\_\_  
Home Phone Cell Phone

\_\_\_\_\_  
Business Phone Employer

\_\_\_\_\_  
Occupation Email Address

\_\_\_\_\_  
Mother's Full Name

\_\_\_\_\_  
Address Apt

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
SS# Birthdate

\_\_\_\_\_  
Home Phone Cell Phone

\_\_\_\_\_  
Business Phone Employer

\_\_\_\_\_  
Occupation Email Address

## Nearest Relative/Friend

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address Apt

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Relationship

\_\_\_\_\_  
In case you are not at home, what is your neighbor's

\_\_\_\_\_  
Name Phone

## Financial Information

### Method of Payment:

Please check one:

Check or cash at time of treatment

Visa, Mastercard, American Express or Discover

Other: \_\_\_\_\_

• Payment is expected at time of treatment.

• All emergency patients (being seen for the first time) are required to pay in full at time of treatment.

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same.

I accept responsibility for payment of services rendered for \_\_\_\_\_ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

\_\_\_\_\_  
**SIGNED (parent or legal guardian)**

\_\_\_\_\_  
**DATE**