New Patient Form

Today's Date:

MONTCLAIR Pediatric Dental CARE

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

Does your child have tooth or mouth pain today? ☐ 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
☐ Cancer
☐ Cardiac (Heart Conditions)
☐ Congenital Birth Defects
☐ Developmental Delay
☐ Diabetes
☐ Food Allergies
☐ Hearing Impairment
☐ Heart Murmur
☐ Hemophilia/Blood Disorders
☐ Hepatitis
☐ HIV + / AIDS
☐ Kidney/Liver Conditions
☐ Pregnancy
☐ Reflux/GI Problems
☐ Rheumatic/Scarlet Fever
☐ Seizures
☐ Skin Rash
☐ 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

Are all immunizations up to date? ☐ 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

SSN: _____ DL#: _____

Employer: _____

Work #: _____

Home #: _____

Cell #: _____

Email Address: _____

Preferred Contact Method (check all that apply):

☐ Cell Phone ☐ Home Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations (check all that apply):

☐ Cell Phone ☐ Home Phone ☐ Email ☐ Text

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

☐ Internet Search ☐ Word of Mouth ☐ Dental Insurance Website ☐ Other (Please Write Below)

_____

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, that it be held in the strictest of confidence, and 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 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 _____