New Patient Information

Child's Name:___________________________Nickname:________________Date of Birth:_____________
Address:_____________________________________City_________________State________Zip__________
SSN:__________________________ Sex: Male __ Female __
Child's Physician:____ Phone:________________________
Physician's Address:_______________________________City_____________ State________Zip__________

Parent/Guardian Information

Parent/Legal Guardian:______________________________________ Relationship to patient______________
Employer:________________________ Work Phone:_________________ Home Phone:__________________
Cell Phone:______________________ Date of Birth:_________________ SSN:________________________
Email:__________________________
How would you like to receive appointment reminders: phone__ email__
Parent/Legal Guardian:________________________________ Relationship to patient:__________________
Employer:________________________ Work Phone:_________________ Home Phone:__________________
Cell Phone:______________________ Date of Birth:_________________ SSN:________________________
Email:__________________________
With whom does the child reside?____

Insurance Information

Primary Insurance Coverage

Subscriber:_____________________________Date of Birth:______________ SSN:___________________
Carrier:_____________________________ Subscriber#:____________________ Group#:________________
Provider Benefits and Claims Department Phone: _ _____________________________________
Address:_____________________________________City_________________State________Zip__________

Emergency Contact Information

Name:____ Relationship:_________________________________
Home Phone:_________________________ Work Phone:_________________ Cell Phone:__________________

Referral Source:____

Child's Dental History

Please tell us the reason for your child's dental visit:____
Has your child ever visited a dentist before? YES__ NO__
- Name of previous dentist:____ Phone:____________________
- Date of last cleaning? _____________________________ Were x-rays taken? YES_____ NO_____
Has your child experienced any unfavorable reaction from previous dental care?
- If yes, please explain:____
Has your child ever had an adverse reaction to local anesthetic, nitrous oxide sedation, oral sedation or general anesthesia? ____
Does your child have an oral habit?
- (Please check): THUMB___ FINGER___ PACIFIER___ OTHER______________________________
Do you have concerns about how your child's teeth fit together (crooked/crowded?) YES____ NO____
Does your child go to bed with a bottle or sippy cup? YES___ NO___
Does your child snack frequently? YES___ NO___
Is your home water supply fluoridated? YES___ NO___ UKNOWN___
Do you still help your child brush and floss? YES___ NO___
Is your child experiencing dental pain/infections? YES___ NO___
Has your child experienced dental trauma? YES___ NO___ Please explain:_____________________
Is there anything we should know about your child that would make his/her experience more enjoyable?
____

Please see back for further information->

Child's Medical History

Is your child in good health? YES___ NO___ Date of last exam:______________________________

Has your child ever been hospitalized? YES___ NO___ Please explain:___________________________

Does your child have any allergies? YES___ NO___ Type:_____________________________________

Is your child currently taking any medications?

- Please list medication/dose/reason:____

Are your child's immunizations current? YES___ NO___

Has your child been told to take antibiotics before dental treatment? YES___ NO___

Were there any complications at your child's birth? YES___ NO___

- Please explain:____

Do you consider your child to be (please check one):

__Advanced in the learning process __Progressing Normally __Slow in the learning process

Please check if your child has been treated for any of the following:

_ Heart Disease	_ Heart Murmur	_Bleeding/Transfusions
_ Anemia	_ Blood Problems	_ Tonsil/Adenoid Problems
_ Liver/GI Disease	_ Sickle Cell Disease/Trait	_ Diabetes
_ Kidney Disease	_ Rheumatic fever	_ Hepatitis
_ Speech/Hearing	_ Seizures	_ Cleft Lip/Palate
_ Eyesight	_ Congenital Birth Defects	_ Mental Health
_ Recurrent Headaches	_ Hormone/Growth Problems	_ Adverse drug reactions
_ Significant Injuries	_ Frequent Ear Infections	_ Autism
_ ADHD/ADD	_ Spina Bifida	_ Asthma/breathing
_ Tuberculosis	_ HIV/AIDS	_ Mental Delays
_ Physical Delays	_ Cancer/tumors	_ Cerebral Palsy

OTHER: ____

Please take a moment to explain any conditions checked above: ______________________________

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Consent for Dental Treatment

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Halley White/Dr. Andrew Johnson and their staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, x-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. White/Dr. Johnson, whether or not I am present when the treatment is rendered. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. White/Dr. Johnson will provide an environment that will help your child cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Dr. Halley White / Dr. Andrew Johnson of any changes in my child's medical status.

Legal Guardian Signature: ___________________________________ Date:______________________

Doctor Notes and Attestation:____

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____ Date:______________________