New Patient Form

PATIENT INFORMATION

Date ____________

Patient Name ________________________ Date of Birth ___________

Address ____

City _______________________ State _________________ Zip Code ______________

If the patient is a student, Name of School ____

City _______________________ State _________________ Zip Code ______________

FATHER/GUARDIAN INFORMATION

Name ______________________________ Date of Birth ___________

Address ____

City _______________________ State _________________ Zip Code ______________

Home Phone # __________________ Cell Phone # ____________________

Work Phone # ___________________ Email Address _____________________________

Employer _______________________ Occupation _______________________________

Social Security # __________________ Driver License # ___________________________

Relationship to Patient ____

New Patient Form

MOTHER/GUARDIAN INFORMATION

Name ________________________________ Date of Birth ___________

Address ____

City ________________________ State __________________ Zip Code _______________

Home Phone # ___________________ Cell Phone # _____________________

Work Phone # ____________________ Email Address ______________________________

Employer ________________________ Occupation _________________________________

Social Security # ___________________ Driver License # ____________________________

Relationship to Patient ____

INSURANCE INFORMATION

Name of Policy Holder ______________________________ Date of Birth ______________

Address ____

City ________________________ State __________________ Zip Code _______________

Home Phone # ___________________ Cell Phone # _____________________

Work Phone # ____________________ Email Address ______________________________

Employer ________________________ Occupation _________________________________

Social Security # ___________________ Driver License # ____________________________

Relationship to Patient ____

Insurance Company ____

Group ID ______________________________ Subscriber ID ___________________________

Insurance Address ____

City ________________________ State __________________ Zip Code _______________

New Patient Form

MEDICAL INFORMATION

Child's Physician ____________________________ Physician Phone # ___________________

Address ____

City ________________________ State __________________ Zip Code _______________

Is child under care of physician now? Yes ☐ No ☐

Receiving any medication or drugs? Yes ☐ No ☐

List of Medication ____

Has the child been hospitalized? Yes ☐ No ☐

Has the child ever had surgery? Yes ☐ No ☐

Allergies ____

Is there excessive bleeding when cut? Yes ☐ No ☐

Has the child had any history of or difficulty with any of the following?

A.D.D./A.D.H.D. ☐ Autism ☐ Convulsions ☐ Hearing ☐ Problems Rheumatic Fever ☐

A.I.D.S./H.I.V. ☐ Bladder problems ☐ Diabetes ☐ Heart Problems ☐ Anemia ☐

Sinus Problems ☐ Cancer ☐ Drug/Alcohol Abuse ☐ Hepatitis ☐ Thyroid Disease ☐

Asperger's ☐ Cerebral Palsy ☐ Epilepsy ☐ Kidney Disease ☐ Tuberculosis ☐

Asthma ☐ Chicken Pox ☐ G tube/Peg Tube ☐ Liver Disease ☐

Other ____

____

New Patient Form

DENTAL INFORMATION

Referring Doctor ___________________ Date of Last Dental Visit ___________________

Reason For Last Dental Visit ____

Has your child complained about pain? Yes ☐ No ☐

Has your child had any injuries to mouth, teeth, or head? Yes ☐ No ☐

Does your child brush daily? Yes ☐ No ☐

Does your child floss daily? Yes ☐ No ☐

Does your child floss daily? Yes ☐ No ☐

Mouth Habits - Thumb Sucking, Pacifier, Sleeping With Bottle, etc.? Yes ☐ No ☐

EMERGENCY CONTACT

Name _____________________ Number ______________ Relationship _______________

Name _____________________ Number ______________ Relationship _______________

New Patient Form

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child ever has a change in health.

Consent

I am the parent, guardian, or personal representative of ____________________________ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with Name of Insurance Company(ies) and assign directly to Dr. Reena Patel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Reena Patel may use my child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

____ _________________________

Please print name of Parent, Guardian, or Personal Representative Relationship to Child

____ ____________________

Signature of Parent, Guardian or Personal Representative Date