New Patient Form

How did you hear about us? _____

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 ☐

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