GROWING SMILE
PEDIATRIC DENTISTRY AND BRACES

NEW PATIENT FORM

508.731.0808 | mykidszonedental.com

About Your Child

Child's Name _____

Name Child Prefers To Be Called_____

Age _____ Gender ___ Date of Birth _____

Address _____

City _____ State ___ Zip _____

Home Phone _____

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'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? ❑ Yes ❑ No If yes, ❑ Seldom ❑ Often

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
❑ 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
❑ Heart ailment or murmur. Type, if known_____

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 tooth brushing supervised? ❑ Yes ❑ No

By whom?_____

Is dental floss used? ❑ Yes ❑ No

Does your child receive:

❑ Fluoride tablets/drops
❑ Fluoridated water
❑ Fluoride in vitamins
❑ Bottled water
❑ Well water

Responsible Party

_____
Mother's Full Name

_____
Address Apt

_____
City State Zip

_____
SS# Birthdate

_____
Home Phone Cell Phone

_____
Business Phone Employer

_____
Occupation Email Address

Dental Insurance: ❑ Yes ❑ No

_____
Insurance Company Group or Plan Number

_____
Insurance Company Phone

_____
Father's Full Name

_____
Address Apt

_____
City State Zip

_____
SS# Birthdate

_____
Home Phone Cell Phone

_____
Business Phone Employer

_____
Occupation Email Address

Dental Insurance: ❑ Yes ❑ No

_____
Insurance Company Group or Plan Number

_____
Insurance Company Phone

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

Methods of Payment:

❑ Check or cash at time of treatment
❑ Visa, Mastercard, American Express or Discover
❑ Insurance form with co-payment at time of treatment
❑ 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.
- Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to Dentistry for Children, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

_____
SIGNED (Guarantor)

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**