New Patient Information

Child's Name: First: _____ Last: _____ Male Female
Preferred Name: _____ Birth date: _____ Age: _____
Mailing Address: _____
City, State, Zip Code: _____
Child lives with: (Circle one) Father Mother Both Other
Marital Status of parents: (Circle one) Married Single Divorced Separated Widowed

GUARDIAN: _____(Circle One) Mother Father Other _____
Social Security Number: _____ Birth date: _____
Employer: _____ Work Phone:_____
Home Address if different than child's:_____
Home Phone: _____Cell Phone:_____ Best time to contact: _____
_____
Email:_____

GUARDIAN: _____(Circle One) Mother Father Other _____
Social Security Number: _____ Birth date: _____
Employer: _____ Work Phone:_____
Home Address if different than child's:_____
Home Phone: _____Cell Phone:_____ Best time to contact: _____
_____
Email:_____

PERSON FINANCIALLY RESPONSIBLE
Name: _____
Social Security Number: _____ Birth date: _____
Employer: _____ Work Phone:_____
Home Address if different than child's:_____
Home Phone: _____ Cell Phone: _____ Best time to contact: _____

PRIMARY DENTAL INSURANCE:
Name: _____
Phone:_____
Policy #: _____
Subscriber: _____
Birth Date: _____

SECONDARY DENTAL INSURANCE:
Name: _____
Phone: _____
Policy #:_____
Subscriber: _____
Birth Date: _____

Please turn over and complete the back side of this form

DENTAL HISTORY:

Why is your child here today?_____
Is your child currently taking fluoride?_____ How often?_____
Has your child been to the Dentist before? _____If so, date when last seen: _____
How was your child's experience?_____
Has your child had x-rays taken before? If so, date taken: _____
Is your child currently on the bottle?_____ Pacifier? _____Sippy Cup?_____
Nursing? _____ Thumb Sucking?_____ Grinding?_____
Do you currently help your child brush and floss? _____
How often does he/she brush?_____

MEDICAL HISTORY:

Name of Physician:_____ Office: _____
Date of last physical exam:_____ Any findings?_____
Are your child's immunizations up to date?_____
Is your child currently taking any medications?_____If yes, what? _____
Does your child have allergies/adverse reactions to medications, latex, or other substances?
If so, what? _____

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?
PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

□ ADHD
□ AIDS
□ Allergies_____
□ Anemia
□ Artificial joints
□ Asthma
□ Blood Disease
□ Blood transfusion
If yes, date:_____
□ Behavioral/learning disorder
□ Breathing/lung problems
□ Cancer/Tumor
□ Congenital birth defects
□ Endocrine System
□ Fainting
□ Hearing/Sight
□ Heart Murmur
□ Heart Condition
□ Head Injury
□ Frequent headaches
□ Kidney Disease
□ Liver disease
□ Mental disorder
□ Mental/Physical development delay
□ Multiple ear infections
□ Tubes in ears
□ Radiation treatment
□ Respiratory treatment
□ Respiratory problems
□ Rheumatic Fever
□ Seizures
□ Tuberculosis
□ Down Syndrome
□ Vomiting/Diarrhea
□ Pregnancy
Due Date:_____
□ Any other medial condition not listed? _____
_____
_____
_____

Because your child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental examination or treatment can be started by Dr. Young or his staff. Our examination may include dental radiographs (x-rays) and other diagnostic aids, depending on your child's specific needs. Photographs for diagnosis, treatment planning, and teaching purposes may be taken.

I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic reaction or unusual reaction to drugs, food, anesthetics, or other allergens; any body diseases, gum or skin reactions, abnormal bleeding, heart conditions; any other conditions related to my child's health, or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Your child's specific needs will be explained to you after the examination and prior to treatment. We will also review with you the treatment that was performed when completed.

Consent is hereby given for diagnostic, restorative and surgical treatment for my child.

Signature: _____Date: _____
Relationship to child:_____

I have been given the opportunity to review the "HIPAA PRIVACY POLICY" Act.
If you would like a copy to take with you please see the front desk

Signature: _____Date: _____