NEW PATIENT FORM

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:

1. Parent/Legal Guardian: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____ Home Phone: _____
Cell Phone: _____ Date of Birth: _____ SSN: _____
Email: _____
2. Parent/Legal Guardian: _____ Relationship to Patient: _____
Employer: _____ Work Phone: _____ Home Phone: _____
Cell Phone: _____ Date of Birth: _____ SSN: _____
Email: _____
3. With whom does the child reside? _____
4. How would you like to receive appointment reminders? Phone__ Email__ Both___

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 to Patient: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

REFERRAL SOURCE: _____ Phone: _____

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? YES_____ NO_____
  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?

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? YES___ NO___
  If so, 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___
  If so, 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 explain any of the conditions: _____

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 Sunshine Children's Dentistry 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 Sunshine Children's Dentistry, 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. Sunshine Children's Dentistry 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 Sunshine Children's Dentistry of any changes in my child's medical status.

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR NOTES & ATTESTATION: _____

_____

_____ DATE: _____