Vienna Family Dentist

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NEW PATIENT (CHILD)

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ABOUT YOUR CHILD

Today's Date: ____________________ File #: __________

Child's Name: ______________________________
Last First MI

What they prefer to be called: ______________ ☐ Male ☐ Female

Child's Birthday: __________ Age: ______ SSN: __________

School: ______________________ Grade: __________

Child's Home Phone #: ______________________

Child's Home Address: ______________________

City: ______________ State: ______ Zip: __________

Referred By: ______________________________

____
(If doctor, please give address and phone number.)

CHILD'S FAMILY INFORMATION

Who is accompanying this child today?

Name: ______________________________
Last First MI

Relation: ______________________________

Do you have legal custody of this child? ☐ Yes ☐ No

How many siblings? ________ Age(s): ______________

Mother's Name: ______________________________
(☐ Stepmother ☐ Guardian)

Home Address (☐ Same as child): ______________________

City: ______________ State: ______ Zip: __________

Home Phone #: ______________________________

Work Phone #: ______________________ Ext: ______

Mother's DOB: ______________ SSN: ______________

Driver's License #: ______________________

Employer: ______________________ How long? ____

Employer's Address: ______________________

Father's Name: ______________________________
(☐ Stepmother ☐ Guardian)

Home Address (☐ Same as child): ______________________

City: ______________ State: ______ Zip: __________

Home Phone #: ______________________________

Work Phone #: ______________________ Ext: ______

Mother's DOB: ______________ SSN: ______________

Driver's license #: ______________________

Employer: ______________________ How long? ____

Employer's Address: ______________________

INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: ______________________________

Mailing Address: ______________________________

City: ______________ State: ______ Zip: __________

Phone #: ______________________________

Insured's ID #: ______________________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________________
Last First MI

Relation: ______________ DOB: ______________

Insured's Employer: ______________________________

Does either policy cover Orthodontics? ☐ Yes ☐ No

Secondary Dental Insurance

Co. Name: ______________________________

Mailing Address: ______________________________

City: ______________ State: ______ Zip: __________

Phone #: ______________________________

Insured's ID #: ______________________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________________
Last First MI

Relation: ______________ DOB: ______________

Insured's Employer: ______________________________

ACCOUNT INFORMATION

Person Ultimately Responsible for Account

Name: ______________________________
Last First MI

Relation: ______________________________

Billing Address: ______________________________

City: ______________ State: ______ Zip: __________

SSN: ______________ DOB: ______________

Driver's License #: ______________________________

Work Phone #: ______________________ Ext: ______

______ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

CHILD'S MEDICAL HISTORY

What medications is the child taking?

☐ Ritalin ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers
☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin
☐ Other(s), please List: ______________________________________

____

Child's Physician: ____
Child's Physician Phone #: __________________________________
Last Medical Exam: ____

Do the child have or have you had any of the following diseases, medical conditions or procedures?

Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Diabetes/Hypoglycemia
☐	☐	Rheumatic Fever	☐	☐	Hemophilia
☐	☐	Artifical Heart Valves	☐	☐	Abnormal Bleeding
☐	☐	Congenital Heart Defect	☐	☐	Cleft Lip/Palate
☐	☐	Scarlet Fever	☐	☐	Birth Defects
☐	☐	Surgeries/Operations	☐	☐	High/Low Blood Pressure
☐	☐	Cancer/Tumors	☐	☐	Hepatitis
☐	☐	Chemotherapy	☐	☐	Artificial Bones/Joints/Implants
☐	☐	Jaw Problems (TMJ/TMD)	☐	☐	Liver/Kidney/Organ Problems
☐	☐	Hearing Problems	☐	☐	HIV+/Aids/ARC
☐	☐	Tonsillitis	☐	☐	Tuberculosis
☐	☐	Respiratory Problems	☐	☐	Psychiatric Problems
☐	☐	Asthma/Difficulty Breathing	☐	☐	Hyper Active/ADD
☐	☐	Blood Transfusion(s)	☐	☐	Fainting/Seizures/Epilepsy
☐	☐	Leukemia/Anemia	☐	☐	Cerebral Palsy

Please list any other surgeries or medical conditions the child has or has ever had: ______________________________________

____

Is the child allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin
☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Foods: __________
☐ Other: ____

Please rate your general health from 1-10:__________

Does the child wear contact lenses? ☐ Yes ☐ No

Has the child ever taken the drug Ritalin? ☐ Yes ☐ No
If yes, for how long? ______________________________________

Child's blood type:____

Does the child do any of the following?
☐ Thumb/finger sucking
☐ Tongue thrusting/sucking
☐ Heavy snoring
☐ Mouth breathing
☐ Lip sucking/biting

UPDATE (Office Use):

____
Initials Date Comment
____
Initials Date Comment
____
Initials Date Comment

CHILD'S DENTAL INFORMATION

What is the reason for today's visit?

☐ Exam ☐ Emergency ☐ Consultation

Is the child in pain? ☐ Yes ☐ No If yes, How long? ______________

Does the child have any of the following problems?

Y	N	
☐	☐	Discomfort, Clicking or Popping Jaw
☐	☐	Red, Swollen or Bleeding Gums
☐	☐	Sensitive Tooth, Teeth or Gums
☐	☐	Blister/Sores In or Around the Mouth
☐	☐	Lost/Broken Fillings
☐	☐	Teeth Grinding
☐	☐	Ringing In Ears
☐	☐	Broken/Chipped Tooth
☐	☐	Stained Teeth
☐	☐	Locking Jaw
☐	☐	Bad Breath
☐	☐	Loose Tooth
☐	☐	Other:________________________________

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous dentist: ____

Previous dentist's Phone #: ________________________________

Date of last dental exam: ________________________________

Date of last dental X-ray: ________________________________

How many times a day does child brush? ____________________

How many times a week does child floss?____________________

Is child's water fluoridated? ☐ Yes ☐ No

How would you rate child's smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly mutual understanding between provider and patient.

If account is not paid within 45 days of billing, you will be responsible for legal fees, collection agency fees, interest charges and any other expense incurring your account. Our policy requires that bills be paid upon receipt and patient is responsible for paying any upaid balance remaining that was not covered by patient's insurance company.

I authorize the staff to preform and necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I have received a copy of this office's **Notice of Privacy Practices**.

____
Signature: ☐ Parent/Guardian ☐ Other Date