Rivergate DENTAL

NEW PATIENT CHILD FORM

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____
Last First MI

Nickname: _____ ❒ Male ❒ Female

Birthdate: ___ / ___ / ___ Age: ____ SS#: _____

Child's Home #: |_____|_____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

School: _____ Grade: _____

GENERAL INFORMATION

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have custody of this child? ❒ Yes ❒ No

Whom may we THANK for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Relative or Friend not living with you:

Name: _____

Phone: |_____|_____

Address: _____

_____
City State Zip

PARENT'S INFORMATION

Who is responsible for account? _____

Parent's Marital Status:

❒ Single ❒ Married ❒ Divorced ❒ Partnered ❒ Separated

❒ Father ❒ Step Father ❒ Guardian

Name: _____ Birthdate: ___ / ___ / ___

Address: _____

_____

Home #: |_____|_____

SS#: _____ DL #: _____

WK #: |_____|_____ Cell #: |_____|_____

E-Mail Address: _____

Employer: _____

❒ Mother ❒ Step Mother ❒ Guardian

Name: _____ Birthdate: ___ / ___ / ___

Address: _____

_____

Home #: |_____|_____

SS#: _____ DL #: _____

WK #: |_____|_____ Cell #: |_____|_____

E-Mail Address: _____

Employer: _____

MEDICAL HISTORY

Why did you bring the child to the dentist today? _____

_____

Has the child ever taken any diet pills such as Phen-Fen? ❒ Yes ❒ No
(Also known as Redux or Pondimin.) If so, when? _____

Does the child require antibiotics before dental treatment? ❒ Yes ❒ No

Has the child ever had a serious/difficult problem associated with previous dental work? ❒ Yes ❒ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Does the child brush his/her teeth daily? ❒ Yes ❒ No

Floss his/her teeth daily? ❒ Yes ❒ No

Child's Physician: _____

Phone #: |_____|_____ Date of last visit: _____

Is the child currently under the care of a physician? ❒ Yes ❒ No

Please describe the child's current physical health:

❒ Good ❒ Fair ❒ Poor

Please list all prescription/over the counter or supplement drugs that the child is currently taking: _____

_____

Aside from the items listed, please list all drugs/things that the child is allergic to: _____

Y N Latex Y N Metals/Nickel Y N Plastic

Has the child experienced the following medical problems:

Y N Abnormal Bleeding/Hemophilia
Y N ADD/ADHD
Y N Anemia
Y N Any Hosptial Stays/Operations?
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer /Chemotherapy
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are the child's immunizations current? ❒ Yes ❒ No

Anything you would like to discuss with the Doctor in private? ❒ Yes ❒ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue/Cheek Biting
Y N Tongue Thrust
Y N Used Pacifier

MEDICAL and HIPAA STATEMENT of UNDERSTANDING and ACCEPTANCE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that Rivergate Dental follows HIPAA privacy policies and procedures and I have been informed and offered a copy of the HIPAA policy. I understand that it is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date