Gindi Pediatric Dental Group

New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: ______________________________
Last First Middle

Goes by: ____________________ ☐ Male ☐ Female

Siblings that we treat: ______________________

Child's Birthdate: ____/____/____ Child's Age: ________

School: ______________________________

Child's Home #: (____)________________________

SSN: ______________________________

Child's Home Address: ______________________________

____
City State Zip

2 MOTHER'S INFORMATION

Name: ______________________________

Mother Stepmother Guardian Birthdate: ____/____/____

Address: ______________________________

____
City State Zip

Employer: ______________________________

Work #: (____)________________________

Home #: (____)________________________

Cell #: (____)________________________

SSN: ________________ DL#: ________________

Email Address: ______________________________

3 FATHER'S INFORMATION

Name: ______________________________

Father Stepfather Guardian Birthdate: ____/____/____

Address: ______________________________

____
City State Zip

Employer: ______________________________

Work #: (____)________________________

Home #: (____)________________________

Cell #: (____)________________________

SSN: ________________ DL#: ________________

Email Address: ______________________________

4 WHO MAY WE THANK FOR REFERRING YOU?

____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: ______________________________

Relationship: ______________________________

Do you have legal custody of this child? ☐ YES ☐ NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________________

Relationship: ______________________________

Billing Address: ______________________________

____
City State Zip

Work #: (____)________________________

Home #: (____)________________________

Cell #: (____)________________________

Email Address: ______________________________

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____
City State Zip

Insurance Phone #: (____) ________________________

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

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ____/____/____

Insurance ID: ______________________________

Policy Owner's Employer or Union: ________________

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____
City State Zip

Insurance Phone #: (____) ________________________

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

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ____/____/____

Insurance ID: ______________________________

Policy Owner's Employer or Union: ________________

9 DENTAL HISTORY

Is this your child's first visit to the dentist? ____________________

If not, how long since the last visit to the dentist? ____________________

Previous dentist's name: ____________________

Were any x-rays taken at previous dental visits? ____________________

Have there been any injuries to the teeth, face or mouth? __________

If yes, please explain: ____________________

____

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Why did you bring your child to the dentist today? ____________________

____

____

Do any of these apply to your child?

Y	N	Lip Sucking / Biting	Y	N	Nail Biting
Y	N	Nursing / Bottle Habits	Y	N	Thumb / Finger Sucking
Y	N	Negative Dental Experience	Y	N	Mouth Breathing
Y	N	Sweet Tooth	Y	N	Emotional Problems

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: ____________________

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Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or 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

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y	N	Abnormal Bleeding	Y	N	Handicaps/Disabilities
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Disease/Murmur
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV + / AIDS
Y	N	Cancer	Y	N	Kidney/Liver Conditions
Y	N	Congenital Birth Defects	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions/Epilepsy	Y	N	Allergies to Latex Product
Y	N	Pregnancy	Y	N	Diabetes
Y	N	Tuberculosis	Y	N	Hemophilia/Blood Disorders
Y	N	ADD/ADHD	Y	N	Reflux/GI Problems

Please discuss any serious medical conditions the child has had:

____

____

Please list all the drugs the child is currently taking: ____________________

____

Please list all drugs the child is allergic to: ____________________

____

Child's Physician: ____________________

Phone #: (_____) ____________________

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:

GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____________________ ____________________

Signature of Parent or Guardian Date Relationship to Patient

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials ____________________ Date ____________________

Doctor's Comments ____________________

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