Date: _____

New Patient Form

We welcome you and thank you for choosing our office. Please take a moment to fill out the following form as completely as possible.

Patient Information:

Name of Child: _____ Nickname: _____

Sex: M__ F __ Age _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Cell Phone: _____ Alternate Phone: _____

Email:_____

Dental History:

Whom may we thank for referring you? _____

Is this your child's first time seeing a dentist? Y__ N__

If no: Previous Dentist: _____ Date of last visit: _____ X-Rays Taken? Y__ N__

Please describe any relevant information regarding your child's previous experience: _____

_____

Y__ N__ Does your child have dental pain? If yes, where? (please describe) _____

_____

Y__ N__ Does your child brush his/her teeth? How often? _____ With help from an adult? Y__ N__

Y__ N__ Does your child floss? How often? _____ With help from an adult? Y__ N__

Y__ N__ Did/Does your child go to bed with a bottle? Contents: __ Milk __ Water __ Juice

Y__ N__ Is/Was your child nursed to sleep?

Y__ N__ Is/Was your child breast fed? Until what age? _____

Y__ N__ Is your child's water fluoridated? Source: __ City __ Well __ Bottled Other: _____

Does your child have any habits? (Check all that apply)

__ Nail Biting __ Thumb Sucking __ Grinding __ Pacifier __ Mouth Breathing __ Cheek Biting
__ Tongue Thrusting __ Snoring __ Disruptive Sleep

Y__ N__ Has your child ever seen an orthodontist? If yes, who? _____

Y__ N__ Has your child ever experienced trauma to the lips, chin, teeth, or gums?

If yes, when?_____ Please explain: _____

Y__ N__ Has your child ever had any adverse reaction(s) to any dental procedures? If yes, please explain: _____

_____

Do you have any concerns regarding (check all that apply):

__ Speech __ Grinding __ Infant nursing (latch) __ Snoring __ Bad breath (halitosis) __ Enamel conditions

If any checked, please describe: _____

_____

_____

Medical History:

Child's Physician: _____ Medications: _____ Allergies: _____

Y__ N__ Born full term? If no, weeks born: _____

Y__ N__ Is your child under the care of a physician now?

Y__ N__ Receiving any medications or drugs? If yes, please describe: _____

Y__ N__ Ever been hospitalized? If yes, please describe: _____

Y__ N__ Ever had surgery? If yes, which surgery? _____

Y__ N__ Is there excessive bleeding when cut?

Has the child had any history of or difficulty with any of the following? If yes, please place an "x" before all that apply:

__ A.D.D./A.D.H.D.	__ Autism	__ Convulsions	__ Hearing Problems	__ Rheumatic Fever
__ A.I.D.S./H.I.V.	__ Bladder Problems	__ Diabetes	__ Heart Problems	__ Sinus Problems
__ Anemia	__ Cancer	__ Drug/Alcohol Abuse	__ Hepatitis	__ Thyroid Disease
__ Asperger's	__ Cerebral Palsy	__ Epilepsy	__ Kidney Disease	__ Tuberculosis
__ Asthma	__ Chicken Pox	__ G tube/Peg tube	__ Liver Disease	__ Other: _____

If "x" marked, please provide details of conditions, medications, surgeries, relevant history: _____

_____

_____

Emergency Contact Information:

In the event of an emergency, who should we contact?

Name: _____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Authorization:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child ever has a change in health.

Child Consent

I am the parent, guardian, or personal representative of _____

(Please Print Name of Child)

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____

(Name of Insurance Company/Companies)

and assign directly to Dr. Denise Maniakouras all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Denise Maniakouras may use my child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Parent, Guardian, or Personal Representative Relationship to Parent