

New Patient Information Form



Please provide the following confidential **PATIENT** information:

Name: _____

Address: _____

City, State: _____

Zip: _____

School: _____

Date of Birth: ___/___/___ Age: _____

Gender: Male Female

Home Phone: _____

Cell Phone: _____

E-Mail: _____

Parents/Guardians: _____

Parent's Marital Status: _____

**Please indicate your preferred contact method



There's more on the other side!

Getting to know your child:

Is the patient a relative of another of our patients? _____

Who referred you to our office?

What is your child's favorite:

TV Show? _____

Hobby? _____

Person? _____

Of what is your child most proud?

Temperament: Is your child...

shy aggressive happy

Has your child had any unfavorable medical or dental experiences?

Account Information

Please complete the following for each parent:

Name: _____

Date of Birth: ___/___/___

Relation to Patient: _____

Occupation: _____

Employer: _____

Business Phone: _____

Social Security #: _____

Insurance Carrier: _____

ID #: _____

Group #: _____

primary secondary

Name: _____

Date of Birth: ___/___/___

Relation to Patient: _____

Occupation: _____

Employer: _____

Business Phone: _____

Social Security #: _____

Insurance Carrier: _____

ID #: _____

Group #: _____

primary secondary

Medical and Dental History



Please describe what you would like to achieve from today's visit:

Child's Pediatrician: _____

Address: _____

Approximate date of last visit: _____

Child's Height: _____ Child's Weight: _____

Does the child have a history of any major illnesses?

Is the child:

In good health? _____

Taking any medications? _____

Allergic to any medications? _____

Does the child have a tendency toward colds or ear infections? _____

Have the child's tonsils or adenoids been removed?

Name of child's previous dentist: _____

Approximate date of last visit: _____

Does your child have speech problems? _____

Is your child a mouth breather at night or day?

Does your child suck a finger, thumb, pacifier or blanket?

Are there habits that have been discontinued?

How long ago? _____

Have there been injuries to the face or mouth in the past?

Have other family members had orthodontic treatment?

Please check any of the following conditions that apply to your child:

- Diabetes
- Fever Blisters
- Heart Trouble
- Rheumatic Fever
- AIDS, HIV
- Bone Disorders
- Tuberculosis
- Seizure Disorders
- Asthma
- Chicken Pox
- Kidney Disorders
- Liver Problems
- Endocrine Problems
- Prolonged Bleeding
- Fainting or Dizziness
- Immune Disorders
- Neuro-Muscular Disorders



Don't forget to complete the other side!!!

Consent: The undersigned hereby authorizes Melissa Connell, DDS to take x-rays, study models, photographs or any other diagnostic aides deemed appropriate by her to make a thorough and complete diagnosis of my child's dental needs. I also authorize Melissa Connell, DDS to perform treatments, provide medications and therapies that may be indicated in connection with (print patient's name) _____'s dental health care from now until the time I revoke such consent in writing. I understand that responsibility for payment of dental services in this office for my dependents or myself is mine, due and payable at the time of services being rendered.

Signature: _____ Date: ____ / ____ / ____ Relationship: _____