Amazing Kidz
PEDIATRIC DENTISTRY

NEW PATIENT INTRODUCTION

REFERRAL INFORMATION

Who can we thank for telling you about our office?

_____

PATIENT INFORMATION **TODAY'S DATE:** _____

Reason for today's Appointment: _____

Last Name_____ First Name _____ MI ____ Gender _____

Preferred Name _____ Date of Birth ___/___/___ Age _____

Address_____ Apt#_____

City _____ State _____ Zip _____ Home Telephone_____

Emergency Contact: Name_____ Cell Phone_____

Other family members treated at this office_____

PARENTAL INFORMATION

Mother

Name_____

Date of Birth ____/____/____

Social Security#_____

Cell Phone#_____

Email_____

Single _____ Married _____

Widowed _____ Divorced _____

Separated _____ Guardian _____

Employer _____

Address _____

Telephone_____

Complete if DIFFERENT from Patient's home information:

Home Address_____

City_____ State___ Zip_____

Home Telephone_____

Father

Name_____

Date of Birth ____/____/____

Social Security#_____

Cell Phone#_____

Email_____

Single _____ Married _____

Widowed _____ Divorced _____

Separated _____ Guardian _____

Employer _____

Address _____

Telephone _____

Complete if DIFFERENT from Patient's home information:

Home Address_____

City_____ State___ Zip_____

Home Telephone_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Company _____

Address_____

City_____ State___ Zip_____

Insurance Telephone_____

Policy/ Group#_____

Policy Holder_____

Relationship to Patient_____

Secondary Insurance

Company _____

Address_____

City_____ State___ Zip_____

Insurance Telephone_____

Policy/ Group#_____

Policy Holder_____

Relationship to Patient_____

DENTAL HISTORY

Previous dentist (if any) _____ **Date of last dental exam**_____

What concerns you most about your child's dental health? _____

Does your child have dental pain? Y _____ N ____ Level of pain (1-10) _____

Mouth habits? (Please cheek) Thumb sucking _____ Pacifier _____ Mouth Breather _____

Still on bottle _____ Finger habit _____ Tooth grinding _____ None _____

Has your child ever had a negative dental experience in the past? _____

If yes, please explain _____

How often do you and your child brush? _____ **Floss?** _____

Has your child received fluoride supplements? Y _____ N ____ **If yes, what kind?** _____

Are you happy with the appearance of your child's teeth? _____

MEDICAL HISTORY

Is your child under the care of a physician at this time? Y ____ N ____

Provide name and phone #. Explain:_____

Is your child taking any medication? Y _____ N ____ If yes, what: _____

_____

Does your child have allergies? (medications, food, latex, seasonal, etc.) Y _____ N ____

If yes, to what: _____

Has your child ever had a serious illness or been hospitalized? Y _____ N ____ Date: _____

Explain: _____

Has you child ever had oral sedation, I.V. sedation, or general anesthesia? Y _____ N ____

Explain: _____

Are all your child's immunizations current? Y _____ N ____

Has your child ever been advised to take an antibiotic prior to any dental treatments? Y _____ N ____

If yes, antibiotic name and method:_____

Is there any other information that we should know about your child's health?

_____

Please answer the following. Has your child ever had a history of:

Y	N		Y	N	
		ADD/ADHD (circle one)			Heart Condition type? _____
		AIDS or H.I.V. Positive			Heart Murmur
		Anemia			Heart Pacemaker
		Artificial Heart Valve			Heart Surgery date: _____
		Asthma			Hemophilia type? _____
		Autism			Hepatitis type? _____
		Birth defects			Jaw Pain
		Blood Disorders /Bleeding Problems _____			Kidney Trouble
		Brain Injury			Leukemia
		Cancer			Liver Disease
		Cerebral Palsy			Psychiatric Treatment
		Cleft lip/Palate			Respiratory Lung Disease
		Developmental Delayed			Rheumatic Fever
		Diabetes			Scoliosis
		Earaches			Sickle Cell
		Emotional Problems			Speech Problems
		Epilepsy (seizures)			Syndrome type? _____
		Fainting Spells			Tonsillitis
		Headaches			Tuberculosis
		Hearing/Sight Impaired _____			Ulcers

- ❑ Other (ie. use of Epi Pen, allergy shots, etc.): _____
- ❑ Has your child been diagnosed with an infectious disease(s)? (ie. HIV, Hep B, C, other)_____
- ❑ **This child has never been diagnosed as having any of the above conditions.**

I certify that the information given is correct and give my consent to Amazing Kidz Pediatric Dentistry to treat my child's dental needs. I will inform the dentist promptly of any updates to the above information if something changes to help in providing the best care possible to my child.

Signature _____ Date _____

(Please Circle One) Parent, Guardian, Other

Reviewed By _____ Date _____

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