New Patient Information

CHILD"S INFORMATION

Child's name _____
Nickname _____
Child's SSN _____
Date of birth _____
Age _____
Gender _____

Home address _____
City _____
State _____
Zip code _____
Child's school/daycare _____
Who brought the child today?_____
Are you the child's guardian?_____

CAREGIVER INFORMATION

Name _____
Relation to child?_____
Legal guardian?_____
SSN_____
Address_____
City_____
State _____
Zip_____
Employer _____
Occupation _____
Contact Phone #_____
Email_____
How would you like to receive notifications?
phone text email

CAREGIVER INFORMATION

Name _____
Relation to child?_____
Legal guardian?_____
SSN_____
Address_____
City_____
State _____
Zip_____
Employer _____
Occupation _____
Contact Phone #_____
Email_____
How would you like to receive notifications?
phone text email

DENTAL INSURANCE

(If you have your insurance card with you skip this section. We can make a copy of your card instead.)

Insurance company _____
Address _____
Insurance phone # _____
Group # _____
ID# _____
Policy owner's name _____
Policy owner's relation to patient _____

Policy owner's DOB _____
Policy owner's SSN _____
Policy owner's employer _____

SOCIAL INFORMATION
Please list any of your child's special interests (color, sport, cartoon...)
_____
_____
_____

Is there anything we should know that we have not asked about above?
_____
_____
_____

DENTAL INFORMATION
Why did you bring your child today? _____
Is this your child's first dental visit? _____
Why did you choose to change dentists? _____
Has your child been experiencing any dental pain? _____
Has your child experienced any major injuries to their mouth, face, or teeth?
_____
_____
_
Do you believe your child will be cooperative for today's visit? Explain
_____
_____

How often does your child brush? _____
How often does your child floss? _____
Does your child use fluoride toothpaste? _____
Does your child take fluoride supplements? _____

Because the patient is a minor, it is necessary that signed permission be obtained from a parent or guardian before dental care can be rendered. As the person bringing the child to the visit I am acting as his/her guardian at this time. I authorize the team at White Oak Pediatric Dentistry to perform appropriate preventative and therapeutic dental services for this child in accordance with accepted standards of pediatric dental care. The information I have given is correct to the best of my knowledge, that it will be held in strict confidence, and it is my responsibility to inform the office of any changes in the child's medical status moving forward.

Guardian's name _____

Guardian's Signature_____

Date_____