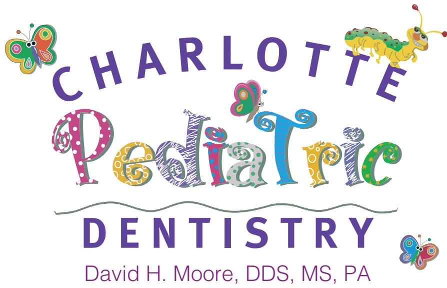

We're in the Business of Children's Smiles

www.CltPediatricDentistry.com

New Patient Information

Today's Date ______________________

1 Child's Information

Last Name First Name Middle Name Name Child Goes By

Address ______________________ City/State/Zip ______________________

Telephone Numbers: Home __________ Cell ______________ Date of Birth ___/___/_____

Place of Birth: ______________ Sex: ☐ M ☐ F Age _____ Weight _____ Height _____

Favorite Hobbies/Interests ______________________

Name of School or Day Care______________________

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other______________________
(If Other, please fill in relationship to child)

Have you traveled outside the U.S. in the past 12 months?: Y N Where?______________

Names and ages of Brothers/Sisters: ______________________

Child's Physician ______________________ Telephone Number ______________

When was your child's last physicians visit? ______________________

How did you find out about our office?______________________

2 Responsible Party Information

Mother/Guardian Name ______________________ Date of Birth ______________
(If different than above)

Address/City/State/Zip ______________________ Home/Cell Number ______________

Email Address ______________________ SS # ______________

Employer______________ Occupation ______________ Work Number ______________

Father/Guardian Name ______________________ Date of Birth ______________
(If different than above)

Address/City/State/Zip ______________________ Home/Cell Number______________

Email Address ______________________ SS #______________

Employer______________ Occupation ______________ Work Number ______________

Emergency Contact Name (Friend/Relative not living with you) ______________________

Home/Cell Number______________ Address/City/State/Zip ______________________

3 Insurance Information

Primary Insured's Name ______________________ Relationship to Child ______________

Insured's: SS # ______________ Date of Birth ___/___/_____ Group Policy # ______________

Name of Insurance Co. ______________________ Telephone ______________

Primary Insured's Employer ______________________ Telephone6______________

3 Insurance Information (continued)

I hereby authorize payment of the dental benefits otherwise payable to me to be paid directly to David H. Moore, DDS, MS, PA. *I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.*

Signature of the Insured ______________________ Date ____________

4 Medical History

Has your child ever had any of the following medical problems? (Circle appropriate response)

Y N Allergies
Y N Anemia or Blood Disorders
Y N Asthma or Hay Fever Please indicate type and current medications: ______________ ______________
Y N Autism
Y N Bladder/Kidney Problems
Y N Bleeding/Bruises Easily
Y N Blood Transfusion
Y N Blood Pressure, High/Low
Y N Bronchitis
Y N Cancer/Chemotherapy
Y N Cerebral Palsy
Y N Congenital Heart Defect If yes, are Premed needed? Y N
Y N Convulsions/Seizures, Fainting or Epilepsy
Y N Childhood Illnesses
Y N Diabetes
Y N Down Syndrome
Y N Handicap, Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hepatitis, Liver Problems
Y N HIV/AIDS
Y N Learning Disorder
Y N Psychological, Emotional Problems
Y N Rheumatic Fever
Y N Speech Disorder
Y N Tuberculosis

Is child allergic to any of these drugs: ☐ Penicillin ☐ Amoxicillin ☐ Erythromycin ☐ Codein ☐ Dental Anesthetic

Is child allergic to any other drugs? Y N If yes, please list: ______________________

Is child allergic to: ☐ Latex ☐ Red Dye ☐ Eggs ☐ Nuts ☐ Drug ☐ Other, please list:

Are child's immunizations current? Y N Please explain: ______________________

List any drugs or medications child is currently taking: ______________________

____

5 Dental History

Date of last Dental visit ____________ Name of Dentist ______________

Do you have current Records (including x-rays) from another practice? Y N

Has child complained about any dental problems? ______________________

Any injuries or surgeries to mouth, teeth, head? Y N If yes, please describe: ______________

____

Does child still take a bottle or sippy cup? ________ What does child usually drink? ____________

Does child brush daily? Y N How often? ________ Do you assist child with brushing? Y N How often? ________

Is Dental Floss used? Y N

Please check each box if child has any of the following mouth habits: ☐ Thumb Sucking ☐ Mouth Breathing ☐ Pacifier ☐ Nail Biting ☐ Finger Sucking ☐ Grinding ☐ Other: ______________

How does your child receive Fluoride?

☐ Water Supply ☐ Dentist ☐ Toothpaste ☐ Vitamins ☐ Tablets ☐ None ☐ Other: ____________

What is child's attitude towards Dentistry? ______________________

Reason for today's visit and your chief concerns: ______________________

____

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I will be responsible for any professional fees incurred for dental services for my child. I understand that I am responsible for all charges whether or not covered by insurance. All balances over 30 days are subject to a 1.5% per month finance charge.

Signed ______________________ Date ____________

Relationship to Child ______________________