NEW WAVE
PEDIATRIC DENTISTRY
& ORTHODONTICS

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Please Tell Us About Your Child

For your convenience please print this form, complete all information, and bring it with you on your first visit.

Childs Name_____
Last First MI
Nickname (if any)_____ Male____ Female_____
Siblings_____
Childs Birthdate_____/_____/_____ Childs age_____
Child's Home #(_____)_____SS#_____
Childs Home Address:_____
_____

Childs Physician_____ Phone (_____)_____
Address_____
Whom may we thank for referring you to our office?_____

Parents/Guardian Information

Parent #1_____Birthdate_____/_____/_____
Employer_____Occupation_____
Work#_____Home #_____Cell #_____
SS#_____Email_____
Address (if different from patient)_____

Parent #2_____Birthdate_____/_____/_____
Employer_____Occupation_____
Work #_____Home#_____Cell#_____
SS#_____Email_____
Address(if different from
patient)_____
_____

Who is accompanying the Child Today?
Name_____

Relationship_____Do you have custody of the child Y N

Person Responsible for the Account
Name_____ Relationship_____
Billing Address (if different from home address)_____

Primary Dental Insurance

Insurance Company Name_____
Insurance Company Address_____
Insurance Company Phone #_____
Policy Owner's Name_____
Relationship to Patient_____
Policy Owners Birthdate_____/_____/_____ SS#_____
Policy Owners Employer_____

Secondary Dental Insurance

Insurance Company Name_____
Insurance Company Address_____
Insurance Company Phone #_____
Policy Owner's Name_____
Relationship to Patient_____
Policy Owners Birthdate_____/_____/_____ SS#_____
Policy Owners Employer_____

Dental History

Is this your childs first visit to the dentist? Y N If no, how long since the last visit to the dentist?_____ Were any x-rays taken at the previous dental visits?_____
Have there been any injuries to the teeth, face or mouth? Y N If yes, please explain_____
Why did you bring your child to the dentist today?_____
How do expect your child to react to his/her visit today?_____
Does your child have any of the following habits?
Y N Lip sucking/biting Y N Nail biting Y N Nursing/bottle habits
Y N Thumb/finger sucking Y N Pacifier habit
Has your child ever had a serious or difficult problem associated with previous dental work? Y N If yes, please explain_____
_____
Is your child taking Prescription Fluoride Vitamins? Y N
Has your child ever had any pain or tenderness in his/her jaw joint? (TMJ/TMD)? Y N
Does your child brush his/her teeth daily? Y N Floss his/her teeth daily? Y N

Health History

Please describe your child's current physical health

Good Fair Poor

Please list all the Medications your child is currently taking_____

_____

Please list all medications your child is allergic to_____

_____

Has your child ever had any of the following conditions?
Please circle Yes or NO for each one

Y N ADD/ADHD
Y N Abnormal Bleeding
Y N Allergy to Drugs
Y N Allergic to Latex
Y N Anemia
Y N Blood disorders
Y N Hospital Stays
Y N Any Operations
Y N Asthma
Y N Autism/Aspergers
Y N Cancer/tumors
Y N Cerebral Palsy
Y N Child Abuse
Y N Chronic Adenoid/Tonsil Infection
Y N Cleft Lip/Palate
Y N Congenital Birth Defects
Y N Epilepsy/Seizures
Y N Developmental delay
Y N Diabetes
Y N Handicaps
Y N Hearing/Speech
Y N Heart Disease
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+ /AIDS
Y N Kidney Disease
Y N Liver Disease
Y N GI disease
Y N PDD
Y N Physical delays
Y N Pregnancy
Y N Premature birth
Y N Rheumatic Fever
Y N Syndrome/type
Y N Thyroid disease
Y N Tuberculosis
Y N Other

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the doctors and staff to provide my childs dental treatment and the necessary dental services on my child including but not limited to x-rays, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis and grant this office permission to provide my child's necessary dental treatment.

Insurance Information

Your insurance policy is a contract between you, your employer and your insurance company. Therefore, you are responsible for understanding your coverage, benefits, and yearly maximum. An authorization will be required to bill your insurance company. Please sign below so we will have this on file.

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I am responsible for all copayments, deductibles, and rejected charges.

_____ _____

Signature of Parent/Guardian Date