OAKRIDGE DENTISTRY

New Patient Form - Child

Child's Name:_____Date:_____

DOB (DD/MM/YY):_____

Home address:_____

Home Phone:_____Cell:_____

Mothers name:_____Work#:_____Cell:_____

Fathers name:_____Work#:_____Cell:_____

School attended:_____

Is this your child's first visit to a dental office?_____

If not, when was your child's last dental visit?_____

What was done for your child at that time?_____

Has your child had any recent dental X-rays?_____

Any previous problems at a dental office?_____

Is your child having any dental problems at the present time?_____

Name of person or office, if any, that referred you?_____

Who is responsible for payment of this account?_____

Do you, your spouse, or both have dental insurance?_____

If yes, please fill in the following section completely.

INSURANCE INFORMATION

Primary Coverage

Name of insured:_____

Is insured person a patient here?_____Insured's DOB:_____

Insurance plane name:_____

Group#:_____ID#:_____%covered:_____

Insured's employer's name:_____phone#:_____

Patient's relationship to insured Self? Spouse? Child? Other?

Secondary Coverage

Name of insured:_____

Is insured person a patient here?_____Insured's DOB:_____

Insurance plane name:_____

Group#:_____ID#:_____%covered:_____

Insured's employer's name:_____phone#:_____

Patient's relationship to insured Self? Spouse? Child? Other?

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MEDICAL HISTORY

Child's medical doctor:_____Phone# or city:_____

Is your child under a Physicians care for any problems?:_____

Name of any medications taken by your child:_____

Does your child have now or in the past (please check off those that apply):

____Heart problems

____Blood disorders

____Diabetes

____Autism/Aspergers

____Special needs

____Fainting/Seizures/Epilepsy

____Asthma

____ Liver or kidney disorder

____ADHD

Serious illness or hospitalization (past or present):_____

Drug allergies (circle): Penicillin Codeine Anaesthetics

Others not listed:_____

Allergies (general):_____

Any condition or problem not listed above:_____

Is there anything else we should know about your child to help us treat him/her?

_____

_____

To the best of my knowledge, this information is complete and correct. If my child ever has a change in his/her health, I will inform the doctors at the next dental appointment.

Parent/Guardian's signature_____ Today's date_____