thank you for selecting us.

Newington Children's Dentistry
www.ourfavoritedentist.com

Date _____

Child's Name _____ (Last / First / MI)

Nickname _____ Gender ☐ Male ☐ Female

Date of Birth _____ Age _____ Phone _____

Your Child

School _____ Grade _____ SS# _____

Child's Address _____ City _____ State _____ Zip _____

Who is accompanying child today? _____ Relationship _____

Whom may we thank for referring you to our office? _____

Name and ages of other children in family _____

Responsible Party

Name _____ Relationship _____

Address _____ SS# _____ DL # _____

Email _____ Phone - Home _____ Cell _____ Work _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

Name _____ Address _____

Email _____ Phone - Home _____ Cell _____ Work _____

Employer _____ Occupation _____ SS# _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

Name _____ Address _____

Email _____ Phone - Home _____ Cell _____ Work _____

Employer _____ Occupation _____ SS# _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Information

Name _____ Address _____

Relationship _____ Phone - Home _____ Cell _____ Work _____

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Over Please

Has your child ever had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Aids/HIV*	☐	☐	Diabetes	☐	☐	Pneumonia
☐	☐	Attention Deficit/Hyperactivity	☐	☐	Drug or Alcohol Abuse	☐	☐	Pregnancy
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Psychiatric Disorder
☐	☐	Allergy/Asthma	☐	☐	Endocrine/Growth Disorders	☐	☐	Rheumatic Fever
☐	☐	Autism	☐	☐	Eye Problems	☐	☐	Scarlet Fever
☐	☐	Bleeding Abnormalities	☐	☐	Fainting/Dizziness	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hearing Loss	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	Heart Disease/Murmur	☐	☐	Sinus Problems/Snoring
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Sore Throat (frequent)
☐	☐	Cerebral Palsy	☐	☐	Hepatitis	☐	☐	Enlarged Tonsils/Adenoids
☐	☐	Chicken Pox	☐	☐	Jaundice	☐	☐	Spina Bifida
☐	☐	Cleft Lip/Palate	☐	☐	Leukemia	☐	☐	Tuberculosis
☐	☐	Communicable Disease	☐	☐	Measles	Other		
☐	☐	Convulsions/Seizures	☐	☐	Mental Retardation	☐	☐	_____
☐	☐	Developmental Delay	☐	☐	Mumps	☐	☐	_____

Please explain any checked items _____

☐ This child has never been diagnosed as having any of the above conditions.

How often does your child brush? _____ Floss? _____

Is brushing/flossing supervised? ☐ Yes ☐ No By Whom? _____

Is the child's water fluoridated? ☐ Yes ☐ No ☐ Don't Know

Is your child receiving fluoride supplements? ☐ Yes ☐ No

☐ Tablets ☐ Drops Dose _____

Is this your child's first dental visit? ☐ Yes ☐ No

Previous Dentist & City _____

Date of last visit _____ Date of last dental x-rays _____

Any injuries to your child's teeth or jaw? ☐ Yes ☐ No

When/What? _____

Has your child had recent dental pain? ☐ Yes ☐ No

Explain _____

☐ Breast-feeding (till Age) _____ ☐ Bottle (till Age) _____

☐ Thumb/Finger Sucking ☐ Pacifier ☐ Nail Biting

☐ Dental Grinding/Clenching ☐ Mouthbreathing/Snoring

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐ Yes ☐ No Explain _____

Child's Physician _____ Phone _____

Address _____

Date of last exam (list results) _____

Please list any serious medical problem, hospitalizations, surgeries the child has had _____

Please list all medications the child is currently taking (Give reasons) _____

Premedication prior to dental treatment? ☐ Yes ☐ No Why ? _____

Is your child under the care of a specialist for any medical reason? ☐ Yes ☐ No Why ? _____

Specialist's Name _____ Phone _____

Does your child have a physical or medical disability/delay? ☐ Yes ☐ No Please list _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Is the child up to date on immunizations? ☐ Yes ☐ No **Do you wish to speak to the doctor privately about a special concern?** ☐ Yes ☐ No

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

Dentist's Review _____

_____

_____

_____

_____ _____

Signature of Dentist Date