Doering
Family Dental

DATE: _____/_____/_____

NEW PATIENT INFORMATION FORM - CHILDREN

Patient Name: _____ Patient Date Of Birth: ____/____/_____

Parent/Guardian Name: _____

Home Address: Street: _____
City: _____ State: _____ Zip: _____

Home Phone: _____
Cell Phone: _____

Parent/Guardian Employed By: _____
Business Address: _____
Present Position: _____
How Long Position Held: _____

Payment Information

Who Will Pay This Account: _____
Purpose of Visit: _____
Patient's Social Security Number: _____
Insured Social Security Number: _____
Name of Dental Insurance Co.: _____
Date of Birth: _____/_____/_____
Email: _____

Referral Information

Please let us know who referred the new patient, if anyone: _____

If you found us as a result of our marketing, please let us know where you remember seeing or hearing about us.
(Please check any and all that you remember.)

___ Friend or Family Referral
___ Google search
___ Google Maps/Local
___ Bing search
___ Bing Maps/Local
___ Email
___ Facebook
___ Yelp!
___ HealthGrades.com
___ ZocDoc.com
___ Phone book (paper version)
___ Online phone book/directory (e.g. SuperPages.com, YellowPages.com, etc.)
___ My dental insurance company
___ Signage on road or outside of our building
___ Radio ad
___ Print ad in: _____
___ Other: _____

If you found us online, please circle one of the following:

I was using a: **COMPUTER** or **SMARTPHONE/TABLET** or **BOTH**

Thank you!

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MEDICAL HISTORY FORM - CHILDREN

Please Circle As Appropriate

1. Does your child have a health problem?..... YES NO
2. Was your child a patient in a hospital?..... YES NO
3. Date of last physical exam: _____/_____/_____
4. Is your child under medical care?..... YES NO
5. Has your child ever had a serious illness or operation?..... YES NO

   If YES, please explain here:

   _____

6. Is your child presently taking any medicines, drugs, pills, or herbal supplements? ..... YES NO

   If YES, please list them here:

   _____

   _____

6. Is your child allergic to (i.e., itching, rash, swelling of hands, feet, eyes, etc.) or made sick by Penicillin, aspirin, codeine, or any drugs/medications?..... YES NO
7. Circle any of the following which your child has ever had or has at present:

HEART FAILURE	EMPHYSEMA	AIDS
HEART DISEASE/ATTACK	COUGH	HEPATITIS A (infectious)
ANGINA (chest pain)	TUBERCULOSIS (TB)	HEPATITIS B (serum)
HIGH BLOOD PRESSURE	ASTHMA	LIVER DISEASE
HEART MURMUR	HAY FEVER	YELLOW JAUNDICE
RHEUMATIC FEVER	SINUS TROUBLE	BLOOD TRANSFUSION
CONGENITAL HEART DEFECT	ALLERGIES/HIVES	DRUG ADDICTION
SCARLET FEVER	DIABETES	HEMOPHILIA
ARTIFICIAL HEART VALVE	THYROID DISEASE	VENEREAL DISEASE (syphilis)
HEART PACEMAKER	X-RAY/COBALT TREATMENT	COLD SORES
HEART SURGERY	CHEMOTHERAPY (for cancer)	EPILEPSY/SEIZURES
ARTIFICIAL JOINT	ARTHRITIS	FAINTING/DIZZINESS
ANEMIA	RHEUMATISM	NERVOUSNESS
STROKE	CORTISONE MEDICINE	PSYCHIATRIC TREATMENT
KIDNEY TROUBLE	GLAUCOMA	SICKLE CELL DISEASE
ULCERS	PAIN IN JAW JOINTS	BRUISE EASILY
MITRAL VALVE PROLAPSE	SLEEP APNEA/SNORING	HIV POSITIVE
CANCER and/or LEUKEMIA		

10. Does your child have to urinate (pass water) more than six (6) times a day?..... YES NO
11. Is your child thirsty much of the time?..... YES NO
12. Has your child had abnormal bleeding from previous surgery/extractions/accidents?... YES NO
13. Does he/she bruise easily?..... YES NO
14. Has he/she ever required a blood transfusion?..... YES NO
15. Does he/she have any blood disorders such as anemia, etc?..... YES NO
16. Has he/she ever had surgery, x-rays or chemotherapy for a tumor growth or other condition?... YES NO
17. Does your child have a disability that prevents treatment in a dental office?..... YES NO
18. Is he/she taking any of the following? (Please circle all that apply.)

ANTIBIOTICS OR SULFA DRUGS	ANTICOAGULANTS (BLOOD THINNERS)	MEDICINE FOR HIGH BLOOD PRESSURE
CORTISONE OR STERIODS	TRANQUILIZERS	ASPIRIN
DILANTIN OR OTHER ANTICONVULSANT	INSULIN, TOLBULTAMIDE, ORINASE, ETC?	ANY OTHER DRUG? _____

19. Is he/she allergic to, or has ever reacted adversely to any of the following?

LOCAL ANESTHETICS	PENICILLIN OR OTHER ANTIBIOTICS	BARBITUATES, SEDATIVES OR SLEEPING PILLS
SULFA DRUGS	ASPIRIN	ANY OTHER DRUG?_____

20. Has he/she had any serious trouble associated with any previous dental treatment?..... YES NO

If YES, please explain here:

_____

21. Has your child been in a situation that could expose him/her to x-rays or other ionizing radiators?... YES NO
22. Date of last dental examination: _____/_____/_____
23. Has he/she ever had orthodontic treatment (e.g. worn braces)?..... YES NO
24. Has he/she ever been treated for any gum disease? (Gingivitis, periodontitis, trench mouth, pyorrhea)?... YES NO
25. Do his/her gums bleed with brushing teeth?..... YES NO
26. Does he/she grind or clench teeth?..... YES NO
27. Has he/she often had toothaches?..... YES NO
28. Has he/she had frequent sores in his/her mouth?..... YES NO
29. Has he/she had any injuries to his/her jaw?..... YES NO

If YES, please explain here:

_____

30. Does he/she have any sores or swelling in his/her mouth or jaw?..... YES NO
31. Have you been satisfied with your child's previous dental care?..... YES NO
32. **ADOLESCENT WOMEN:** Are you pregnant now, or think you might be?..... YES NO
    Do you anticipate becoming pregnant in the near future? ..... YES NO
33. Your child's primary care doctor's name (pediatrician): _____
34. Your child's primary care doctor's (pediatrician's) phone number: _____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has any change in his/her health or if his/her medicines change, I will inform the doctor of dentistry at the next appointment without fail.

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE: _____/_____/_____