Maple Family DENTAL

CHILD NEW PATIENT INFO

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Child Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ___ M ___ F ___ Other

PARENT INFO

Parent Name: _____
Last First MI

Birthdate: _____ SS #: _____

Best phone number to reach parent: _____

Email: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Who is accompanying the child today? Same as above? (if yes, skip this section) ___ Yes ___ No

_____
Last First

Relation to child: _____ Legal guardian? ___ Yes ___ No

How did you hear about us?

_____

Please list family members seen by us: _____

Why did you come to the dentist today?

_____

Is the child's water fluoridated? ___ Yes ___ No

How many times a day does your child brush? ___ 0 ___ 1 ___ 2 or more

How many times a week does your child floss/waterpick? ___ 3 or less ___ 4-6 ___ 7 or more

CHILD MEDICAL HISTORY

List all medications that your child is taking:
1. _____
2. _____
3. _____

Is the child allergic to any of the following?

Y	N		Y	N	
___	___	Anesthetic	___	___	Erythromycin
___	___	Aspirin	___	___	Latex
___	___	Codeine	___	___	Penicillin
___	___	Ibuprofen	___	___	Tetracycline

Other allergies not listed above:

_____

Your child's current physical health is: ___Good ___ Fair ___ Poor

Has the child ever had any of the following medical problems?

Y	N		Y	N	
___	___	Asthma	___	___	Kidney Disease
___	___	Bleeding Problems / Hemophilia	___	___	Liver Disease
___	___	Cancer / Chemotherapy	___	___	Hepatitis
___	___	Diabetes	___	___	Mitral Valve Prolapse
___	___	Anemia	___	___	Rheumatic/Scarlet Fever
___	___	Congenital Heart Defect	___	___	Lupus
___	___	High Blood Pressure	___	___	Mononucleosis
___	___	Heart Murmur	___	___	Tonsilitis
___	___	Herpes/fever blisters	___	___	Seizures / Epilepsy
___	___	Chicken Pox	___	___	Hives
___	___	Measles	___	___	Low Blood Pressure
___	___	Hearing Impaired	___	___	Tuberculosis
___	___	HIV / Aids	___	___	Sickle Cell Disease/Traits
___	___	Artificial Heart Valve	___	___	Radiation Treatment

Other conditions not listed above:

_____

Does/did the child have any of the following habits?

Y	N		Y	N	
___	___	Breast Fed	___	___	Nursing bottle habits
___	___	Chewing on objects	___	___	Used pacifier
___	___	Clenching/Grinding	___	___	Thumb/finger sucking
___	___	Speech Problems	___	___	Tongue/cheek biting
___	___	Mouth Breather	___	___	Tongue thrust
___	___	Nail Biting	___	___	Lip sucking/biting

By signing below, I confirm that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Parent/Guardian Signature:
Date: _____

BASIC CONSENT FOR FIRST VISIT

I consent to my child having the following done: X-rays, Exam, Cleaning.

CHECK HERE: ___

I understand that holding my mouth open during treatment may temporarily leave my child's jaw feeling stiff and sore and may make it difficult to open wide for several days. I must notify your office if this or other concerns arise. I understand that if the recommended treatment is not performed, tooth or gum damage may progress causing loss of one or more teeth. My child may also experience symptoms that may be damaging to overall health and which may increase in severity, and the cosmetic appearance of teeth may deteriorate. I understand that every reasonable effort will be made to ensure the success of my child's treatment. I understand that each person and situation is unique, and no guarantee or assurance has been given to me by anyone that the proposed treatment will cure or improve my child's condition(s).

CHECK HERE: ___

I understand that antibiotics, anesthetics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore it is critical that I tell my dentist of all medications my child is currently taking, which I have done.

CHECK HERE: ___

I understand that my child may have loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) following injections for local anesthesia with any procedure. Rarely, temporary or permanent nerve injury and loss of feeling may result from an injection.

CHECK HERE: ___

SIGN HERE:

TODAY'S DATE: _____

OFFICE USE ONLY
Confirmation of review of medical / dental information above with the patient named herein, and attestation of discussion of the risks, benefits, consequences, and alternatives of proposed treatment. Patient will be given the opportunity to ask questions, and I will ensure the patient understands what has been explained.

Maple Family DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

THIS GIVES US PERMISSION TO SHARE INFORMATION WITH YOUR INSURANCE OR SPECIALISTS, WHEN RELEVANT TO YOUR CARE.

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.)

I HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGN HERE:

FOR OFFICE USE ONLY

We attempted to obtain written acknowedgement of receipt of our Notice of Privacy Practices, as required by law.