New Patient Intake Form

Patient Information

Child's Full Name: _____

Preferred Name/Nickname: _____

Date of Birth: _____ Age: _____ Gender (circle): Male Female Other Prefer not to say

Parent/Guardian Information

Primary Contact Name: _____

Relationship (circle): Mother Father Guardian Other _____

Address: _____

Phone: _____ Email: _____

DOB: _____ SSN: _____

Parental Marital Status (circle) : Married Single Divorced Separated Widowed

Secondary Contact Name: _____

Relationship (circle): Mother Father Guardian Other _____

Address: _____

Phone: _____ Email: _____

DOB: _____ SSN: _____

Parental Marital Status (circle) : Married Single Divorced Separated Widowed

Insurance Information

Primary Dental Insurance:_____

Policy Holder Name: _____

Member ID: _____ Group #: _____

Secondary Dental Insurance:_____

Policy Holder Name: _____

Member ID: _____ Group #: _____

Medical History

Primary Physician: _____

Current medications (circle): Yes No List: _____

Allergies (circle): Yes No List: _____

Up to date on immunizations? (circle): Yes No

Surgery/hospitalization? (circle) Yes No Explain: _____

Medical conditions (circle all that apply):

AIDS/HIV ADHD/ADD Anemia Anxiety Asthma/Breathing difficulties

Autism Spectrum Birth Defects Behavioral problems (ODD/PDD) Blindness

Bleeding disorder (Hemophilia, von Willebrand, etc) Cancer

Cardiac disease/defects Cerebral palsy Cleft lip/palate

Depression Developmental delay Diabetes Down's syndrome

Eczema/skin rash Emotional Problems Hearing loss Intellectual disability

Kidney disease Liver disease Seizures/Epilepsy Speech problems

Other: _____

Dental History

Reason for today's visit: _____

First dental visit? Yes No Previous dentist: _____

Date of last dental visit: _____

Dental trauma? Yes No Describe: _____

Past treatment (fillings, crowns, extractions)? Yes No Describe: _____

Fluoride toothpaste? Yes No If no, what do they use? _____

Flossing: Yes No Occasionally

Oral habits: Thumb sucking Pacifier Nail biting Grinding/Clenching Nursing bottle

Other: _____

Authorization & Consent

I certify the above information is accurate to the best of my knowledge.I authorize the dental team to perform necessary diagnostic procedures and treatment. I authorize billing of my dental insurance and consent to communication with my child's healthcare providers as needed. I acknowledge that I have reviewed the practice's Notice of Privacy Practices (HIPAA).

Signature of Parent/Guardian: _____ Date: _____