New Patient Intake Form

Patient Information

Child's Full Name: _____

Preferred Name/Nickname: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

School/Daycare: _____ Grade: _____

Parent/Guardian Information

Primary Contact Name: _____

Relationship: ☐ Mother ☐ Father ☐ Guardian ☐ Other

Phone: _____ Email: _____

DOB: _____ SSN: _____

Address: _____

Secondary Contact Name: _____ Relationship: _____

Phone: _____ DOB: _____ SSN: _____

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

Insurance Information

Dental Insurance Company: _____

Policy Holder Name: _____ Employer: _____

Member ID: _____ Group #: _____

Medical History

Primary Physician: _____ Date of Last Visit: _____

Under care of physician? ☐ Yes ☐ No If yes, explain: _____

Current medications? ☐ Yes ☐ No List: _____

Allergies? □ Yes □ No List: _____

Up to date on immunizations? □ Yes □ No

Surgery/hospitalization? □ Yes □ No Explain: _____

Medical conditions (check all that apply):

□ ADHD/ADD

□ Anemia

□ Anxiety

□ Asthma/Breathing difficulties

□ Autism Spectrum

□ 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

□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: _____