SETON FAMILY
DENTAL CENTRE

Child New Patient Information

Patient Name: _____ D.O.B: Month _____ Day _____Year _____ Gender: ◯Female ◯Male

Home Address: _____

Parent Name: _____ D.O.B: Month _____ Day _____Year _____ Gender: ◯Female ◯Male

Phone number: _____ Parent email: _____

How did you hear about us?

☐Word of mouth ☐Facebook ☐Internet search / Website ☐Community Newsletter ☐Other clinic in this building ☐Other_____

Dental History:

Previous Dental Clinic: _____ Date of Last Dental Exam: _____

What is the primary reason for today's visit? _____

Is patient in pain? ☐No ☐Yes Explain: _____

Has patient had an injury to the mouth, teeth, or jaw? ◯No ◯Yes Explain: _____

Was/Is the patient: ☐Breastfed. Until what age? _____ or ☐Bottle fed. Until what age? _____

How often does the patient brush teeth? ____/day ☐With help ☐Without help. How often does the patient floss? _____/week

Does the patient:

☐Suck Thumb/Finger ☐Use Pacifier ☐Clench/Grind Teeth ☐Bite Fingernails ☐Speech Issues ☐Mouth Breather

Medical History:

Medical Clinic Name & Phone: _____ Medical Doctor Name: _____

Is patient currently under the care of a doctor? ☐No ☐Yes Explain: _____

Has patient ever had surgery or been hospitalized? ☐No ☐Yes Reason: _____

Family History of Malignant Hyperthermia ☐No ☐Yes When: _____

Does patient have any allergies? ☐No ☐Yes List: _____

Is the patient taking any medications? (Including over the counter / herbal supplements) ☐No ☐Yes

Medication Names: _____

Does patient have/or had any of the following:

☐Congenital Heart Defect / Disease
☐Heart Surgery
☐Heart Murmur
☐High Blood Pressure
☐Rheumatic Fever
☐Asthma / Breathing Issues
☐Cerebral Palsy
☐Seizures / Convulsions / Epilepsy
☐Learning / Communication Problems
☐Autism Spectrum Disorder
☐ADD / ADHD

☐Visual / Hearing Impairment
☐Abnormal Bleeding Issues
☐Sickle Cell Trait / Disease
☐Hemophilia / Anemia
☐Kidney Problems
☐Liver Problems
☐Diabetes
☐Muscle / Bone / Joint Problems
☐Thyroid / Glandular Problems
☐Skin Problems/Hives/Cold Sores
☐Failure to Thrive

☐Eating Disorders
☐Born Prematurely
☐Hepatitis A, B, or C
☐Blood / Blood Product Transfusion
☐HIV / AIDS
☐MRSA
☐Tuberculosis
☐Limited Mobility
☐Other: _____

Immunizations Up to Date ◯Yes ◯No

Are there any other medical conditions or concerns that we need to be aware of?

_____

- **I, the undersigned, confirm that I am the parent / legal guardian of the above child.**
- **To the best of my knowledge all the above answers and information provided are true, complete, and accurate.**
- **I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to my child's medical, insurance or legal guardianship status.**

_____ _____ _____

Signature of Parent / Legal Guardian *Date* *Printed Name*