Animas Pediatric Dental Group-New Patient form

Patient Name ______________________________________ Sex _____ Patient Birth Date ______/______/______ Home Phone ______________________________

Patient Address ______________________ City _________________ State ______ Zip _______ How Long______ Responsible Party__________________________

SS# _________-_________-_________ Physician __________________________________ Referred by ____

Email address ____ How did you hear about us? ____

<u>Mother's Information</u> Legal Custody: Yes No	<u>Father's Information</u> Legal Custody: Yes No	<u>Step Parent Information</u> Legal Custody: Yes No
Name __________________________	Name __________________________	Name__________________________
Address ________________________	Address ________________________	Address________________________
City ___________________________	City ___________________________	City ___________________________
State, Zip ______________________	State, Zip ______________________	State, Zip ______________________
Cell Phone______________________	Cell Phone ______________________	Cell Phone ______________________
Employer _______________________	Employer _______________________	Employer _______________________
Work Phone _____________________	Work Phone _____________________	Work Phone _____________________
INS Name & Grp# ________________	INS Name & Grp# ________________	INS Name & Grp# ________________
Birthdate ________/__________/__________	Birthdate ________/__________/__________	Birthdate ________/__________/__________
SS# __________-__________-__________	SS# __________-__________-__________	SS# __________-__________-__________

Birth Parents: Single Married Divorced Spouse Deceased Separated

Nearest Relative (name, address, phone#) ____________________________________

Reason for Dental Visit____

<u>MEDICAL HISTORY</u>

YES	NO	*Has your child ever had any of the following:*
		1. Rheumatic Fever
		2.Hepatitis/ Liver Disease/ GI Disease
		3. Diabetes
		4. Blood Transfusion
		5. Abnormal Bleeding/ Blood Disorder
		6. Epilepsy/ Seizures
		7. Tuberculosis
		8. Arthritis
		9. Kidney Disease
		10. Thyroid Disease
		11. Hormonal Dysfunction
		12. Allergies to Drugs and Medications
		13. Hay Fever
		14. Asthma
		16. Heart Disease
		17. Heart Murmur
		18. Birth Defects
		19. Hospitalizations
		20. Pneumonia/ Lung Disease
		21. Constant Ear Infection
		22. Anemia
		23. AIDS, or AIDS related complex
If yes, explain: Number, date, and duration		

	YES	NO
Is this your child's first dental visit?		
Is your child in good health?		
Does your child have a mental or physical disability? Explain		
Are there problems with hearing, sight, speech, or learning disorder?		
Did your child have a baby bottle at nap and/or bedtime? How long?		
Does your child have a thumb habit or a pacifier?		
Has your child had an unfavorable reaction to medical/dental treatment?		
Is your child taking any drugs or medicine right now? What?		
Does your child have any other medical problem we should know about?		

CONSENT

Because your child is a minor, it becomes necessary that a signed permission from a parent or guardian before any and/or all dental treatment can be started and completed by the doctor. Our examination may or may not include dental x-rays, depending on your child's specific needs. Photographs for diagnosis, treatment planning and teaching may be made.

Consent is hereby given for restorative and/or surgical dental treatment. The restorative materials used may include plastic fillings, plastic sealants, silver fillings and stainless steel crowns. Restorative treatment may include tooth nerve removal when necessary. Surgical treatment may include but is not limited to tooth removal and minor gum problems. Local anesthesia, nitrous oxide and oxygen are used routinely as needed for your child's comfort.

No sedative drugs are used without prior consent by parent. If it becomes necessary due to a cooperation problem to control or relax the patient by the use of sedatives, you will be consulted in advance. Physical restraint is not used without a parent's consent unless it is needed to protect the child from self-injury.

I acknowledge that I will be responsible for arranging for payment of any bills incurred on the above child for dental treatment. I understand that all charges are due and payable upon receipt of my monthly statement and all delinquencies are subject to outside collections and that I may be responsible for attorney fees and reasonable collection costs. I also agree to and understand that interest may be assessed on the unpaid balance over sixty (60) days delinquent.

Parent/Guardian__________________________________ Date _____________