NEW PATIENT INFORMATION

Name: _____Nickname:_____DOB: _____Gender: ☐ M ☐ F

Street Address: _____

City: _____State:_____ Zip: _____

Who is accompanying the child today? Name: _____Relation: _____

☐ Biological ☐ Adopted ☐ Foster ☐ Nanny ☐ Other:

What is the primary reason for today's visit? : ☐ Establishing a Dentist ☐ Trauma/Dental Emergency

☐ Second Opinion ☐ Other:_____

Has your child ever been to the dentist?: ☐ Yes ☐ No (If Yes) Previous/Present Dentist:_____

Date Last Exam: _____Date Last X-rays: _____

Describe your child: ☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Age appropriate

How would you expect your child to behave in our office?:_____

_____

How may we help make this visit a positive experience for your child?: _____

_____

Does your child currently... (Check all that apply) ☐ Suck Thumb/Finger ☐ Bite/Chew Nails ☐ Use a Pacifier

☐ Clench/Grind Teeth ☐ Mouth Breather ☐ Breast Feed ☐ Bottle Feed

If Breast/Bottle Fed: At what age did you discontinue breast/bottle feeding?_____

Does your child currently use… (Check all that apply) ☐ Fluoride Toothpaste ☐ Consume Fluoridated Water

☐ Fluoride Supplements ☐ Fluoride Mouthwash

Oral Hygiene: ☐ Brushing by Child: _____/day ☐ Brushing by Parent:_____ /day ☐ Dental Floss:_____ /week

☐ Snacks between Meals --Type of snacks:_____

_____

PATIENT HEALTH HISTORY

Are immunizations current? : ☐ Yes ☐ No Child's physician: _____

Phone: _____Date Last Exam: _____ Date Last Tetanus: _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): _____

_____

Current Medications:_____

Has your child been diagnosed and/or treated for any of the following? (Check all that apply)

☐ Food Allergies: _____☐ Medication

Allergies:_____

☐ Other Allergies: _____

☐ Blood Disorder/Anemia	**☐ ADD/ADHD**	**☐ Abnormal Bleeding/Hemophilia**
☐ Asthma/Reactive Airway Disease	**☐ Immune Disorder/HIV/AIDS**	**☐ Mental/Cognitive/Social Delay**
☐ Cancer/Tumor/Leukemia	**☐ Congenital Birth Defects**	**☐ Heart Murmur/Defect/Surgery**
☐ Liver Disease/Jaundice/Hepatitis	**☐ Autism Spectrum**	**☐ Epilepsy/Seizures/Convulsions**
☐ Liver Disease/Jaundice/Hepatitis	**☐ Cerebral Palsy**	**☐ Hearing Problems/Deaf**
☐ Vision Problems	**☐ Stomach/GI Disorders**	**☐ Cleft Lip/Palate**

☐ Kidney Problems ☐ Eating Disorder ☐ Speech Disorder ☐ Diabetes

☐ Other (specify): _____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the child's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that SL Ryan DDS Inc. may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am

responsible for the full balance of the account regardless of my dental benefits and directly assign SL Ryan DDS Inc. all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

SIGNATURE_____**RELATIONSHIP TO CHILD**_____

DATE_____