New Leaf Dental

We Choose To Charge Less-
So You Can Smile More

ABOUT YOUR CHILD

Date: ___/___/_____

Name:_____

I prefer to be called:_____

Birthdate:___/___/____ Gender:_____

Parent or Guardian's Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home #(___)_____ Cell #(___)_____

Work #(___)_____ DL:_____

E-Mail:_____

Employer:_____

Where & When are the best times to reach you?:_____

_____

Other family members being seen by us:_____

_____

Previous/Current Dentist:_____

Last visit date:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____

Birthdate:_____ Social Sec #_____

Cell # (___)_____ Work # (___)_____

INSURANCE INFORMATION

Primary Insurance:

Name of Insured:_____

Relation to Patient:__Self __Spouse __Child __Other

Insured Social Sec #_____

Birthdate: ___/___/_____ Employer_____

Insurance Company_____

Member ID #:_____ Group #_____

Secondary Insurance:

Name of Insured:_____

Relation to Patient:__Self __Spouse __Child __Other

Insured Social Sec #_____

Birthdate:___/___/_____ Employer_____

Insurance Company_____

Member ID #:_____ Group #_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature **Date**

Payment is due in full at the time of treatment unless prior arrangements have been approved.

TURN OVER----->

CHILD'S MEDICAL HISTORY

Physician:_____

Office Phone #_____ Last Exam:__/__/____

Is your child currently under the care of a physician: __No __Yes

Is your child taking any prescription/ over-the-counter drugs/ herbs or vitamins?: __No __Yes
Please list each one:_____
_____

Or Do you have a medication list?__Yes __No

Is your child Allergic to any of the following drugs?:

Y N	Local Anesthetics	Y N	Penicillin
Y N	Aspirin	Y N	Erythromycin
Y N	Amoxicillin	Y N	Latex
Y N	Codeine	Y N	Sulfa Drugs
Y N	Iodine	Y N	Mint
Y N	Other _____		

_____
_____
_____
_____

DOES YOUR CHILD HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Y N	Heart Problems	**Y N**	Leukemia
Y N	Heart Murmur	**Y N**	Cancer
Y N	Rheumatic Fever	**Y N**	Angina
Y N	Diabetes	**Y N**	Asthma
Y N	Fainting/ Seizures	**Y N**	Heart Disease
Y N	Respiratory Problems	**Y N**	Arthritis
Y N	Epilepsy/Convulsions	**Y N**	HIV/AIDS
Y N	Kidney Diseases	**Y N**	Stroke
Y N	Hepatitis/Jaundice	**Y N**	Glaucoma
Y N	Thyroid Problem	**Y N**	Heart Attack
Y N	Hay Fever/Allergies	**Y N**	Liver Disease
Y N	Tuberculosis	**Y**	
N	Stomach Troubles/Ulcers		
Y N	Other_____		

_____
_____
_____

DENTAL HISTORY

Why have you come to the dentist today?:_____

_____

Is he/she currently in pain?: ___No ___Yes

Has he/she ever had a serious/difficult problem associated with any previous dental work?:__No __Yes

Does he/she ever experience pain or discomfort in their jaw joint (TMJ/TMD)? __No __Yes

His/Her current dental health is __Good __ Fair __Poor

Has he/she ever had instruction on the correct method of brushing your teeth? ___No ___Yes

Has he/she ever had instructions on the care of your gums? ___No ___Yes

How many times a day does your child

brush?:_____

How Many times a week does your child

floss?:_____

Has he/she had any orthodontic work? ___No ___Yes

In the event of an emergency, is there someone we should contact?

Name:_____ Relation:_____
Home #:_____ Cell #:_____

How Did you hear about our office?

__ Insurance plan/provider	__Other Doctor
__ Social Media	__ Coupon/Giveaway
__ Google/Website	__ Yellow Pages
__ Friend/Family Referral	__Other_____

Referral's Name:_____

SIGNATURE:_____

DATE:_____