Newark Smiles New Patient (Child)

Personal Information of:

_____

Name **Date**

This personal information will help us to give the most consideration of your time and feelings. It is important to have complete answers. All information is, of course, confidential.

Are you aware of your child having any particular dental problems? _____

Is this your child's first visit to a dental office? _____ If not, how long since last exam? _____

What was done for your child at that time? _____

Has your child ever had any serious illnesses such as rheumatic fever, any heart problems or heart murmer, diabetes, etc?
Yes_____ No_____ If yes, what? _____

Is your child sensitive or allergic to any food or medication? _____ If so, what? _____

Who is your child's physician? _____ Address _____

The date of your child's last medical checkup: _____ Is your child under any treatment? Yes No

If so, for what? _____ What medications does your child take? _____

Is the child's dental work covered by insurance? Yes_____ No_____ If yes, name of Ins Co: _____

Name of policy holder: _____ Social Security #: _____

May we ask who recommended our office? _____

Child's Name _____ Date of Birth _____

Home Address _____ City_____ Zip _____

Home Phone _____ School _____ Grade _____

Mother's name _____ Occupation _____

Where does she work? _____ Work/Cell phone _____ ext _____

Father's Name _____ Occupation _____

Where does he work? _____ Work/Cell phone _____ ext _____

Responsible Person? _____

_____

Parent Signature **Date**

Thank You!

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