



# New Patient Information

Date \_\_\_\_\_

Patient's Full Name \_\_\_\_\_ Preferred name \_\_\_\_\_ Age \_\_\_\_\_

Birthday \_\_\_\_\_ Patient Social Security # \_\_\_\_\_ Sex \_\_\_\_\_

Name and type of child's pet \_\_\_\_\_ Favorite interest \_\_\_\_\_ Favorite Sport \_\_\_\_\_

Home Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Neighborhood \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Name and ages of other children \_\_\_\_\_

Mother \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Father \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Father's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Who has legal custody of patient? \_\_\_\_\_

Dental Insurance      yes      no      Company \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

What is the reason for your child's dental visit? \_\_\_\_\_

## Health History

Yes    No    Is your child in good health? Name of child's physician \_\_\_\_\_

Physician's phone number \_\_\_\_\_

Yes    No    Has your child ever had a health problem? \_\_\_\_\_

Yes    No    Has your child ever been hospitalized? Please give reason and dates \_\_\_\_\_

Yes    No    Is your child allergic to anything (Antibiotic, food, etc)? \_\_\_\_\_

Yes    No    Is your child currently taking any medications? Please give medications and reason \_\_\_\_\_

Please circle if your child has been treated for any of the following:

Heart disease	Bleeding/transfusions	Asthma	Liver disease
Anemia	Kidney disease	Seizures	Rheumatic fever
Hepatitis	Speech/hearing	Diabetes	Cleft lip/palate
HIV/AIDS	Cerebral Palsy	other problems	

Please elaborate \_\_\_\_\_

Do you consider your child to be:

\_\_\_\_\_ advanced in the learning process \_\_\_\_\_ progressing normally \_\_\_\_\_ slow in the learning process

How would you characterize your child's personality? Circle all that apply

- Outgoing      Shy      Stubborn      Anxious      Frightened      Defiant
- Strong Willed    Quiet      Talkative      Suspicious      Moody      High Strung
- Regular kid      Friendly      Cooperative

Was your child breast fed \_\_\_\_\_ How long? \_\_\_\_\_ Was your child bottle fed \_\_\_\_\_ How Long? \_\_\_\_\_

### Dental History

Yes    No    Has your child ever been to the dentist? Name of the dentist and date  
\_\_\_\_\_

Yes    No    Has your child experienced any unfavorable reaction from previous dental care? Please explain  
\_\_\_\_\_

Yes    No    Does your child suck a finger, thumb, or pacifier? \_\_\_\_\_  
How frequently? \_\_\_\_\_

Yes    No    Has your child ever suffered from Dental Trauma? \_\_\_\_\_  
When, and which teeth were involved \_\_\_\_\_

Please circle if your child is having problems with any of the following:

- Cavities                      Toothache                      Teeth sensitivity                      Gum infections
- Color of teeth                      Orthodontics                      Jaw sounds                      Grinding teeth                      Other

How do you expect your child to react to his/her visit today?

- Excellent      Good      Fair      Poor      Not Sure

Is there any additional information we should know that will help us provide a positive dental experience for your child? \_\_\_\_\_  
\_\_\_\_\_

I, being the parent or legal guardian of \_\_\_\_\_ authorize, request and permit Dr. Hansen, and any employees under his supervision to perform any and all manner of Dental-Medical treatment that may be indicated in connection with my child, and to do whatever procedures that the judgment of Dr. Hansen may indicate during treatment. I further authorize the administration of such medication/s, anesthetic/s and the taking of x-rays as may be deemed advisable by Dr. Hansen.

The risks and nature of treatment have and shall continue to be explained to me as treatment progresses and no warranty or guarantee has been made as to the result or cure. I assume responsibility for any and all charges incurred on behalf of my child for Dental-Medical treatment.

Signed \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_