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New Patient Information Form

Eastside Pediatric Dental Group
185 NE Gilman Blvd.
Issaquah, WA 98027
425-392-4048

Name of Child ______________________________ Birthdate ____________ Age_____ Sex M F
Last First

Home Address ____
Street City State Zip

Home Phone ____

Who may we thank for referring you? ______________________________

Email Address ____

Brothers______________________ Sisters______________________

Name of Child's Physician______________________ Telephone____________ Date of last exam__________

Reason for bringing child to dentist ______________________________

Father's/Guardian's	Mother's/Guardian's
Father's/Guardian's Name ______________________	Mother's/Guardian's Name ______________________
Address if different than patient('s) ______________________	Address if different than patient('s) ______________________
Home Phone ____________ (If different than above) Work Phone ____________	Home Phone ____________ (If different than above) Work Phone ____________
Cell Phone ____________	Cell Phone ____________
Soc. Sec. # ______________________	Soc. Sec. # ______________________
Employer ______________________	Employer ______________________
Date of birth ______________________	Date of birth ______________________
Do you have dental insurance coverage for your child? Y☐ N ☐	Do you have dental insurance coverage for your child? Y☐ N ☐
Insurance Company ______________________	Insurance Company ______________________
Subscriber ID ____________ Group # ____________	Subscriber ID ____________ Group # ____________
Address ______________________	Address ______________________
Phone # ______________________	Phone # ______________________

In the event of an emergency, whom should we contact? (other than parents)

Name____________________ Relationship ____________________ Phone ____________________

Name____________________ Relationship ____________________ Phone ____________________

History

1. Is your child being treated by a physician at this time? Yes No
   If yes, why?______________________
2. Has your child ever been significantly injured? Yes No
3. Has your child ever been a patient in a hospital? Yes No
   If yes, why?______________________
4. Is your child allergic to anything? Yes No
   If yes, what?______________________
5. Other than allergies, has your child ever had an adverse or unusual reaction to any medication? Yes No
6. Is your child taking any medication at this time? Yes No
   If yes, what?______________________
7. Does your child have a history of frequent infections? Yes No
8. Has your child ever had a blood transfusion? Yes No
   Date:________________
9. Does your child smoke or use tobacco products? Yes No
10. Has your child ever been seen by a dentist before? Yes No
    Date last seen________ Name of Dentist______________
11. Has your child ever received fluoride in any form? Yes No

12. Does your child suck his/her thumb, fingers or pacifier? Yes No
13. Are your child's teeth brushed once or more a day? Yes No
14. What type of toothpaste does your child use?________________
15. At what age did your child stop bottle/breast feeding?_________
16. Has your child ever had dental x-rays taken? Yes No
    If yes, when?__________ Name of Dentist____________________
17. Has your child ever had problems with his/her jaw joint? Yes No

Organs and Systems

Has your child ever been treated for any of the following?

____ My child has never been treated for any of the following.

Yes	No	Blood/Circulatory	Yes	No	Stomach/GI			
Yes	No	Muscles						
Yes	No	Bones	Yes	No	Kidney/Bladder			
Yes	No	Nervous system						
Yes	No	Endocrine Glands	Yes	No	Heart	Yes	No	Skin
Yes	No	Eyes, Ears, Nose, Throat	Yes	No	Liver	Yes	No	Tonsils/Adenoids
Yes	No	Lungs/Respiratory						

Illness

Has your child ever been diagnosed as having any of the following conditions?

_____ My child has never been diagnosed with any of the following conditions.

Yes	No	ADD/ADHD	Yes	No	Diabetes	Yes	No	Pneumonia
Yes	No	AIDS/HIV	Yes	No	Drug or alcohol abuse	Yes	No	Pregnancy
Yes	No	Anemia	Yes	No	Eating Disorder	Yes	No	Psychiatric Disorder
Yes	No	Allergy _______________	Yes	No	Epilepsy	Yes	No	Rheumatic Fever
Yes	No	Arthritis	Yes	No	Fainting	Yes	No	Scoliosis
Yes	No	Asthma	Yes	No	Hearing Loss	Yes	No	Sickle Cell Anemia
Yes	No	Autism	Yes	No	Headaches	Yes	No	Sinus Problems
Yes	No	Behavior Problems	Yes	No	Heart Defect/Disease/Murmur	Yes	No	Snoring at night
Yes	No	Bleeding Disorder	Yes	No	Hemophilia	Yes	No	Sore Throats-frequent
Yes	No	Brain Injury	Yes	No	Hepatitis-Type_____	Yes	No	Spina Bifida
Yes	No	Bronchitis	Yes	No	Jaundice	Yes	No	Syndrome_____________
Yes	No	Cancer/Tumor	Yes	No	Leukemia	Yes	No	Tetanus
Yes	No	Cerebral Palsy	Yes	No	Learning Disability	Yes	No	Tuberculosis
Yes	No	Cleft lip/palate	Yes	No	Mental Retardation	Yes	No	Vision Impairment
Yes	No	Congenital Birth Defect	Yes	No	Mouth Breathing	Yes	No	Reflux__________
Yes	No	Convulsions	Yes	No	Nutritional Deficiency	Yes	No	Other_____________
Yes	No	Disability/Delay	Yes	No	Orthopedic Problems			

Which best describes your child's personality? (Circle one) Normal Shy Nervous Difficult

Is there anything else that you think we should know about your child? ____
____
____
____
____

I authorize the dental staff to perform the necessary dental services for my minor/child. I understand that I am financially responsible for all charges, regardless of any insurance coverage in place. I certify that *if* my child is covered by insurance, I assign directly to EPDG all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize EPDG to release all information necessary to secure the payment of these benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________ ______________________________ ________________

Signature of person completing form | Relationship to patient | Date