Welcome to the **NEW HOPE - SOLEBURY DENTAL ASSOCIATES** Pediatric Dentist

1 ABOUT YOUR CHILD

His / Her Name: _____

Nickname: _____ ☐ MALE ☐ FEMALE

Birthdate: ____/ ____/ ____ SSN: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

Cell #: (_____) _____-_____ Hm #: (_____) _____-_____

Special interest, sport, or hobbies: _____

_____

_____

2 ABOUT YOU

Name: _____
LAST FIRST MI SALUTATION

Relationship to child: _____

I prefer to be called: _____ ☐ MALE ☐ FEMALE

Birthdate: ____/ ____/ ____ SSN: _____ DL #: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

E-mail Address: _____

Cell #: (_____) _____-_____ Hm #: (_____) _____-_____

Wk #: (_____) _____-_____ Ext: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you?

_____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

3 DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (_____) _____-_____

Group #: _____ ID #: _____

This Dental Insurance is provided through:

Policy owner's (PO) name: _____

Relationship to child: _____

PO's SSN: _____ PO's Birthdate: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Group #: _____ ID #: _____

This Dental Insurance is provided through:

Policy owner's (PO) name: _____

Relationship to child: _____

PO's SSN: _____ PO's Birthdate: _____

Employer: _____

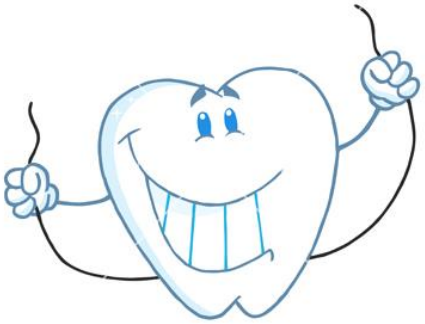
Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Cell #:(_____) _____-_____ Hm #: (_____) _____-_____

CONTINUED ON BACK



4 DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? ☐ Yes ☐ No

Date of last visit? _____

Are there any dental problems that you are aware of at present?

☐ Yes ☐ No If yes, please explain: _____

_____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Please rate your child's oral health: ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? Y N

Child's physician: _____

Phone #: (_____) _____ - _____ Date of last visit: _____

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor\

Is your child allergic to any drugs or other thing? ☐ Yes ☐ No

If yes, please list: _____

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: _____

Does your child require antibiotics before dental treatment?

☐ Yes ☐ No

5 MEDICAL PROBLEMS

Has your child ever had any of the following medical conditions or problems?

Any Hospital Visits	☐ Yes	☐ No
Any Operations	☐ Yes	☐ No
Bleeding Problems of Any Kind	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems of Any Kind	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
HIV+/AIDS	☐ Yes	☐ No
Hyperactive	☐ Yes	☐ No
Rheumatic/Scarlet Fever	☐ Yes	☐ No

Are there any other medical conditions or problems relating to your child? ☐ Yes ☐ No

If yes, please list: _____

_____

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 child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

_____ _____

Signature Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangement has been approves.

Parent/Guardian Signature: _____

Date: _____

Medical History Update

Date: _____ Comments: _____ Parent/Guardian Signature: _____

Date: _____ Comments: _____ Parent/Guardian Signature: _____

Date: _____ Comments: _____ Parent/Guardian Signature: _____

Date: _____ Comments: _____ Parent/Guardian Signature: _____

Date: _____ Comments: _____ Parent/Guardian Signature: _____

Date: _____ Comments: _____ Parent/Guardian Signature: _____

Date: _____ Comments: _____ Parent/Guardian Signature: _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____