New Child Patient Form

Name of Child/Minor: _____ SS#: _____
Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ Cell Phone: _____
Sex: _____M _____F Age: _____ Birth Date: _____
School Name: _____
Person Financially Responsible: _____
How did you hear about our office?: _____

Dental Insurance

Father's Name: _____
Address: _____
Phone Number: _____
_____S _____M _____D
Employer: _____
Work Phone: _____
SS#: _____
Birth Date: _____
Do you have Dental Insurance
Coverage for the Child/Minor?: ____Y ____N

Mother's Name: _____
Address: _____
Phone Number: _____
_____S _____M _____D
Employer: _____
Work Phone: _____
SS#:_____
Birth Date: _____
Do you have Dental Insurance
Coverage for the Child/Minor?: ____Y ____N

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Alderman all Insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-name dentist may use my health care information and disclose such information to the above-named insurance company and their agents for the purpose of obtaining payments for services and determining insurance benefits of the benefits payable for release services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Parent/ Guardian: _____

Health History

Physician's Name _____ Date of last visit _____

Please indicate if you **have** or **have had** any of the following:

- ◯ AIDS / HIV
- ◯ Allergy
- ◯ Anemia
- ◯ Artificial Heart Valve
- ◯ Artificial Joint
- ◯ Asthma
- ◯ Bleeding Problems
- ◯ Blood Transfusion
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Cold Sores
- ◯ Diabetes
- ◯ Emphysema
- ◯ Epilepsy or convulsions
- ◯ Fainting Spells / Seizures
- ◯ Family History of Malignant Hyperthermia
- ◯ Fever Blisters
- ◯ Glaucoma
- ◯ Heart Defect or Murmur
- ◯ High Blood Pressure
- ◯ Hepatitis A (infectious)
- ◯ Hepatitis B (serum)
- ◯ Herpes
- ◯ Heart Trouble / Attack
- ◯ Immune System Disorder
- ◯ Kidney Trouble
- ◯ Prolapsed Mitral Valve
- ◯ Radiation Treatment
- ◯ Rheumatic Heart Disease
- ◯ Pacemaker
- ◯ Sinus Trouble
- ◯ Stroke
- ◯ Taken Cortisone in Past Year
- ◯ Tuberculosis
- ◯ Ulcers

Do you smoke? Yes No

Have you taken bisphosphonate drugs? Yes No

Other: _____

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Allergies

- ◯ Aspirin
- ◯ Codeine
- ◯ Local Anesthetics
- ◯ Penicillin
- ◯ Other allergies: _____
- ◯ Acrylic
- ◯ Latex / Rubber
- ◯ Sulfa Drugs
- ◯ Metals

Women:

	Yes	No
Are you pregnant?	◯	◯
Are you nursing?	◯	◯
Taking birth control pills?	◯	◯

Due Date: _____

If so, is there anything else we should know? _____

Please let us know if you would like a copy of Notice of Privacy Practices HIPAA that is offered to all our patients.

Please list any other person (s) that have permission to access your records and account information:

_____

We are pleased to welcome you to our practice! _____

(Signature of patient or parent / guardian)