Hillsboro Pediatric Dentistry

Your Child's Dental Home

New Patient Form

Today's Date ____ /____ /____

Child's Name _____ Preferred Name _____ Age ____ Date of Birth ____ /____ /____
Address _____ Zip Code _____
Names and Ages of Siblings _____
Hobbies, Pets _____ School _____

Whom may we thank for referring you? _____

Parent

Name _____ Date of Birth ____ /____ /____
Home Address _____ Zip Code _____ SS# _____
Email Address _____ Cell # _____ Home # _____
Occupation _____ Employer _____ DL # _____

Parent

Name _____ Date of Birth ____ /____ /____
Home Address _____ Zip Code _____ SS# _____
Email Address _____ Cell # _____ Home # _____
Occupation _____ Employer _____ DL # _____

Please note that we do not need your SS# if you do not have dental insurance and plan to pay for your visits via cash, check or credit card.

Please share with us how you prefer receiving reminders from our office concerning a scheduled appointment:
[ ] Cell Phone
[ ] Home Phone
[ ] Email

Nanny/Babysitter (whom you have allowed to bring child to appointments and make payments on your behalf)

Name _____ Cell # _____

Payment Information

Credit Card Name _____ CC# _____ Expiration Date ____ /____ Security Code _____

Name of Dental Insurance _____ Group ID # _____
Name of Insurance Holder _____ DOB ____ /____ /____ Insurance Phone# _____
Dental Insurance Claims Mailing Address _____ Zip Code _____

Please note that we plan to file your dental insurance for you through our office electronically to save you the cost of a stamp and to help expedite the processing of your claim so that you may receive payment from your dental insurance promptly.

Dental History

Is this your child's first visit to the dentist? Y/ N
If no, please give us the date of the last visit and the name of the dentist:

Please share with us the reason for your visit today and any concerns you may have:

Has your child ever been treated for dental injury, toothache, or other head or neck emergency?

How has your child handled previous dental treatment (if applicable)?

Do you, as the parent, visit the dentist routinely for check ups? Y / N
Have you, as the parent, had positive dental experiences? Y / N

Medical History

Pediatrician Name _____ Address _____ Phone # _____

Please check any condition that applies to your child and explain further below:

[ ] Bleeding Disorders	[ ] Heart Disease	[ ] Gastro Intestinal Disease	[ ] Seizures	[ ] Asthma
[ ] Neurological Disorders	[ ] Kidney Disease	[ ] Surgeries/Transplants	[ ] Cancer	[ ] AIDS
[ ] Sickle Cell Disease	[ ] Liver Disease	[ ] Down's Syndrome	[ ] Diabetes	[ ] Possibility of Pregnancy

Please state any medical, emotional, or behavioral condition that your child or is suspected of having.
Please be specific: _____
Does your child have any food or seasonal allergies? _____
Does your child have any allergies to medications? _____
Does your child have a LATEX allergy? Y / N
Have you ever been told your child has a heart murmur? Y/ N
Has your child ever seen a cardiologist to evaluate a heart murmur? _____
Result of that visit? _____
Has your child ever needed to take antibiotics prior to a dental visit? _____
Does your child take any medication? If so, please state name and daily dosage schedule: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize and request the performance of dental services for my minor child. I understand that the first appointment will include a doctor's examination, necessary x-rays, cleaning, and topical fluoride treatment. The doctor will explain my child's treatment needs, if any, and the staff will review any associated fees. I understand that any restorative treatment, if needed, will be accomplished at a later appointment, scheduled at the convenience of the parent and child.

I understand that the parent/guardian whose signature appears below is the one that is responsible for all fees when services are rendered and consents to treatment deemed necessary as explained by the dentist or dental professional.

Signature of Parent/Guardian _____ Date _____
Relationship to child: _____