NEW PATIENT INFORMATION FORM

About Your Child

Last Name _____ First Name _____ Middle Initial _____

Age _____ Birth date _____ Nickname _____ ○ Male ○ Female

Last Name _____ First Name _____ Middle Initial _____

Age _____ Birth date _____ Nickname _____ ○ Male ○ Female

Last Name _____ First Name _____ Middle Initial _____

Age _____ Birth date _____ Nickname _____ ○ Male ○ Female

Last Name _____ First Name _____ Middle Initial _____

Age _____ Birth date _____ Nickname _____ ○ Male ○ Female

Home Address

Street _____

Apt # _____ City _____

State _____ Zip Code _____

Mailing Address

Street _____

Apt # _____ City _____

State _____ Zip Code _____

Phone Numbers and Emails

Home # _____ Work Cell # _____

Mom's Cell # _____ Dad's Cell # _____

Mom's Email: _____ Dad's Email: _____

Insurance Information

Does your child have Georgia Medicaid? Yes ○ No ○

Do you have dental insurance coverage for a minor/child ? Yes ○ No ○

Insurance Company Name: _____ Phone # : _____

Group/Plan #: _____ Patient ID: _____

Whom may we thank for referring you? _____

Medical History

Patient's Name: _____

Patient's Physician: _____

City/State: _____ Phone: _____

Date of last physical examination: _____

Current Medical Conditions: _____

List of Allergies (Latex, etc): _____

List of Surgeries: _____

List of Medications: _____

Does patient have Congenital Heart Disease?

Is SBE prophylaxis required?

Is patient receiving any medication or drugs?

Has patient been hospitalized?

Has patient ever had surgery?

Is there excessive bleeding when cut?

Has Patient ever taken Fen-Phen/Redux?

If so, why?

Handicaps/Disabilities?

Dental History

Last Cleaning/Fluoride: / / Last X-rays: / /

Has patient complained about dental problems?	Yes	No
Is fluoride taken in any form?	Yes	No
Does patient brush teeth daily?	Yes	No
Any injuries to mouth, teeth, head?	Yes	No
Does patient floss every day?	Yes	No
Any unhappy dental experiences?	Yes	No
Female: Are you pregnant?	Yes	No
Nursing?	Yes	No

PLEASE SELECT IF PATIENT EVER HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING

- ADD/ADHD ☐
- Congenital Heart Defect ☐
- Hemophilia ☐
- AIDS/HIV ☐
- Convulsions/Seizures ☐
- Herpes ☐
- Anemia (Sickle cell or Low Iron) ☐
- Chemotherapy ☐
- High Blood Pressure ☐
- Asthma ☐
- Diabetes ☐
- Jaw Pain ☐
- Artificial Heart Valves ☐
- Drug/Alcohol Abuse ☐
- Kidney/Liver Disease ☐
- Autism ☐
- Epilepsy ☐
- Learning Disability ☐
- Bladder Problems ☐
- Hearing Impairment ☐
- Measles ☐
- Cerebral Palsy ☐
- Heart Murmur ☐
- Mononucleosis ☐
- Chicken Pox ☐
- Hepatitis ☐
- Mumps ☐

Check if patient has any of the following problems:

Bad Breath ☐	Grinding or clenching teeth ☐	Loose teeth or jaw ☐
Food collection between teeth ☐	Sensitivity to cold ☐	Broken fillings ☐
Periodontal treatment ☐	Sensitivity when biting ☐	Sensitivity to hot ☐
Sensitivity to sweets ☐	Clicking or popping ☐	Sores or growths ☐
Bleeding gums ☐		in mouth

Responsible Party

Last Name _____ First Name _____ ○ Mother ○ Father ○ Other

Marital status : ○ Married ○ Divorced ○ Separated ○ Widowed ○ Single

Address **(If different from patient)** _____

Home Phone **(If different from above)** _____

Work Phone **(If different from above)** _____ Birth date _____

Employer _____ Social Security # _____

Nearest Relative/Friend

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Financial Information

Method of Payment (Please check one):

○ Check or cash at time of treatment. ○ Visa, Mastercard, American Express or Discover

○ Insurance form with co-payment at time of treatment ○ Other: _____

• Payment is expected at time of treatment.

• All emergency patients (being seen for the first time) are required to pay in full at time of treatment.

• Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby author ize payment directly to **PediatricDentistryandorthoSCorp**, the group insurance benefits otherwise payable to me a nd authorize release of information regarding treatment to the insurance company.

Consent for Treatment

The information that I have given is correct and completed to the best of my knowledge. It 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 am the LEGAL GUARDIAN of the patient. I authorize and give consent to Dr. Nath/authorized associates/staff to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I also accept responsibility for payment of services rendered. I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays, and examinations) before that treatment is performed.

MY SIGNATURE BELOW STATES THAT I GIVE CONSENT AND UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS OFFICE.

Patient's Name _____ DOB _____

Parent/Guardian Signature _____ Date _____