GARLAND PEDIATRIC DENTISTRY

New Patient Information Form

Patient Name:_____**Nickname**:_____**Sex**: M__ F___ **DOB**:_____Age:___

Parent's Name/Guardian:_____ **Relationship to Patient**:_____

Address:_____**City:**_____**State:**_____**Zip Code:**_____

Mobile Number: _____**Home:** _____**Work:** _____

Medical Conditions: Has the child had any history of, or conditions related to, any of the following:

___Anemia	___Cancer	___Epilepsy	___HIV +/AIDS	___Mononucleosis	___Thyroid	___Arthritis
___Cerebral Palsy	___Fainting	___Immunizations	___Mumps	___Tobacco/Drug Use	___Asthma	___Chicken Pox
___Growth Problems	___Kidney	___Pregnancy (teens)	___Tuberculosis	___Bladder	___Hearing	___Latex Allergy
___Rheumatic Fever	___Heart	___ Chronic Sinusitis	___Bleeding Disorder	___Diabetes	___Heart	___Liver
___Seizures	___Bones/Joints	___Ear Aches	___Hepatitis	___Measles	___Sickle Cell	

___Other_____

Please List the name and phone number of the child's Physician:

Name of Physician:_____**Phone**:_____

Child's History

1. Is the Child taking any prescription and/or over the counter medications or vitamin supplements at this time?..... 1.Yes__ or No__
   If yes, Please list:_____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs?..... 2.Yes__ or No__
   If yes, please explain:_____
3. Is the child allergic to anything else, such as certain foods? If yes, please explain_____ 3.Yes__ or No__
4. How would you describe the child's eating habits?_____ 4.Yes__ or No__
5. Has the child ever had a serious illness? If yes, when:_____Please describe:_____ 5.Yes__ or No__
6. Has the child ever been hospitalized?..... 6.Yes__ or No__
7. Does the child have a history of any other illnesses? If yes, please list:_____7.Yes__ or No__
8. Has the child ever received a general anesthetic?..... 8.Yes__ or No__
9. Does the child have any inherited problems?..... 9.Yes__ or No__
10. Does the child have any speech difficulties?..... 10.Yes__ or No__
11. Has the child ever had a blood transfusion?..... 11.Yes__ or No__
12. Is the child physically, mentally, or emotionally impaired?..... 12.Yes__ or No__
13. Does the child experience excessive bleeding when cut?..... 13.Yes__ or No__
14. Is the child currently being treated for any illnesses? If yes, please list:_____ 14.Yes__ or No__
15. Is this the child's first visit to the dentist? If not the first visit, what was the date of the last dentist visit?_____15.Yes__ or No__
16. Has the child had any problem with dental treatment in the past? If yes, explain:_____16.Yes__ or No__
17. Has the child ever had dental radiographs (x-rays) exposed?..... 17.Yes__ or No__
18. Has the child ever suffered any injuries to the mouth, head or teeth?..... 18.Yes__ or No__
19. Has the child had any problems with the eruption or shedding of teeth?..... 19.Yes__ or No__
20. Has the child had any orthodontic treatment?..... 20.Yes__ or No__
21. What type of water does your child drink? ___City Water ___Well Water ___Bottled Water ___Filtered Water
22. Is fluoride toothpaste used?..... 22.Yes__ or No__
23. Does the child suck his/her thumb, fingers or pacifier?..... 23.Yes__ or No__

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian Signature:_____ **Date:** _____