ADOLESCENT NEW PATIENT INFORMATION

*PATIENT NAME: FIRST__________________________________ MI_____ LAST______________________________________

DOB________________________ AGE__________ GENDER M or F SSN____

PHONE NUMBER FOR CONFIRMING PATIENT'S APPOINTMENTS____

ADDRESS____ CITY______________________ STATE ______ ZIP_____________

*FATHER'S NAME: FIRST__________________________________ MI_____ LAST______________________________________

HIS DOB____________________ HIS SSN________________________ HIS PHONE NUMBER________________________________

HIS ADDRESS____ CITY______________________ STATE ______ ZIP_____________

HIS EMPLOYER____ OCCUPATION_______________________________________

*MOTHER'S NAME: FIRST__________________________________ MI_____ LAST______________________________________

HER DOB____________________ HER SSN________________________ HER PHONE NUMBER________________________________

HER ADDRESS____ CITY______________________ STATE ______ ZIP_____________

HER EMPLOYER____ OCCUPATION_______________________________________

NAME OF PERSON COMPLETING THIS FORM_______________________________ RELATION TO PATIENT_____________________

HOW DID YOU HEAR ABOUT OUR OFFICE? FRIEND/FAMILY/COWORKER INSURANCE WEBSITE SOCIAL MEDIA

INSURANCE POLICY HOLDER INFORMATION

INSURED'S NAME: FIRST__________________________________ MI_____ LAST______________________________________

INSURED'S DOB_____________ INSURED'S SSN__________________ INSURED'S RELATION TO PATIENT_______________________

INSURANCE COMPANY____ INSURANCE PHONE________________________________

INSURANCE GROUP#____________________ INSURED'S EMPLOYER____

DENTAL HEALTH INFORMATION

	YES	NO
DOES DENTAL TREATMENT MAKE PATIENT NERVOUS?	□	□
DOES PATIENT HAVE ANY SENSITIVITY TO HOT, COLD, OR SWEETS?	□	□
IS PATIENT INTERESTED IN BRACES OR CURRENTLY IN BRACES?	□	□
DOES PATIENT STILL HAVE HIS OR HER WISDOM TEETH?	□	□

DATE OF LAST DENTAL CLEANING? ____

HOW OFTEN DOES PATIENT BRUSH? ____

IS ANYONE HELPING PATIENT BRUSH, IF SO WHEN? ____

DOES PATIENT FLOSS? Y or N HOW OFTEN? ____

DOES PATIENT WATERPIK? Y or N HOW OFTEN? ____

WHAT IS THE MOST IMPORTANT THING TO YOU ABOUT PATIENT'S DENTAL VISIT TODAY? _____________________________

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GENERAL HEALTH INFORMATION

DOES PATIENT HAVE A PRIMARY CARE PHYSICIAN? Y or N
PHYSICIAN'S NAME ______________________________________ PHYSICIAN'S PHONE___________________________

HAS PATIENT HAD ANY SERIOUS ILLNESSES, OPERATIONS, OR HOSPITALIZATIONS? Y or N
IF YES, PLEASE EXPLAIN____

Health History: Please answer yes to anything that pertains to Patient

	Yes	No
• Is your child healthy?	___	___
• Is your child allergic to anything?	___	___
• If so, what? ____		
• Does your child have regular medical exams?	___	___
• Is your child up to date on immunizations?	___	___
• ADD/ADHD	___	___
• Heart conditions	___	___
• Congenital heart defect	___	___
• Lung problems	___	___
• Sinus problems/allergies	___	___
• Coronavirus	___	___
• Liver problems	___	___
• Kidney problems	___	___
• Stomach problems	___	___
• Seizures	___	___
• Diabetes	___	___
• Cerebral palsy	___	___
• Bleeding disorder	___	___
• Anemia	___	___
• Hepatitis	___	___
• Sleep apnea/snoring	___	___
• Tuberculosis	___	___
• Asthma	___	___
• Mentally handicapped	___	___
• Anxiety	___	___
• Depression	___	___
• Autism	___	___
• Speech disorder	___	___
• Hearing disorder	___	___
• Vision disorder	___	___

***PLEASE LIST ALL CURRENT MEDICATIONS OR PROVIDE A MEDICATION LIST:**

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ANY ADDITIONAL COMMENTS:

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I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BENEFITS TO THOMAS DENTAL CARE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH MY DENTAL TREATMENT. I HEREBY AUTHORIZE THOMAS DENTAL CARE TO ADMINISTER SUCH MEDICATION AND PERFORM SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

Patient Name: ______________________________ Date: _______________

Patient Signature: ______________________________

Provider Signature: ___________________________