

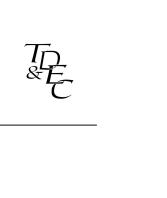
ADOLESCENT NEW PATIENT INFORMATION _____ MI____ LAST_____ *PATIENT NAME: FIRST _____AGE______GENDER M or F SSN_____ PHONE NUMBER FOR CONFIRMING PATIENT'S APPOINTMENTS_____ _____ CITY_____ STATE ____ ZIP____ _____ MI____ LAST___ *FATHER'S NAME: FIRST____ HIS DOB______ HIS SSN_____ HIS PHONE NUMBER___ _____ CITY______ STATE ____ ZIP_____ HIS EMPLOYER_____OCCUPATION_____ *MOTHER'S NAME: FIRST_______MI___LAST______ 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 PHONE_____ INSURANCE COMPANY INSURANCE GROUP#_____ INSURED'S EMPLOYER___ **DENTAL HEALTH INFORMATION**

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



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 	<u> </u>	_					
Heart conditions	_						
 Congenital heart defect 		<u> </u>					
 Lung problems 							
 Sinus problems/allergies 							
Coronavirus							
Liver problems Kidney problems							
Kidney problemsStomach problems							
Seizures							
SeizuresDiabetes							
Cerebral palsy							
Bleeding disorder							
Anemia							
Hepatitis							
Sleep apnea/snoring							
Tuberculosis		_					
 Asthma 							
 Mentally handicapped 							
 Anxiety 							
 Depression 							
Autism							
Speech disorder							
Hearing disorder Vision disorder							
Vision disorder							
*PLEASE LIST ALL CURRENT MEDICATIONS OR PROVIDE	A MEDICATION LIST	T:					
ANY ADDITIONAL COMMENTS:							
I HEREBY AUTHORIZE DIRECT PAYMENT OF MY INSURANCE BET RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH MY DENTAL TADMINISTER SUCH MEDICATION AND PERFORM SUCH DIAGNOST FOR PROPER DENTAL CARE. I UNDERSTAND THE IMPORTANCE INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT OF INFORMATION ABOVE IS COMPLETE AND ACCURATE.	FREATMENT. I HEREBY STIC AND THERAPEUTIO OF A TRUTHFUL HEALT	AUTHORIZE THOMAS DENTAL CARE TO C PROCEDURES AS MAY BE NECESSARY TH HISTORY AND REALIZE THAT					
Patient Name:	Date: _						
Patient Signature:							



Provider	Signature:	