New Patient Form

Thank you for choosing us to care for your child. Dr. Gehrke is a pediatric dentist. Pediatric dentists are the pediatricians of dentistry. As the experts in dental development, pediatric dentists are uniquely qualified to assess your child's changing dental needs and protect your child's dental future. Because we specialize, we make children feel special. Kids feel welcome here. Our office is designed for children and the entire dental team enjoys working with children. Thank you for choosing us.

Dr. Fred, The Kids Dentist

PATIENT INFORMATION

Name __________ Nickname __________ Date of Birth __________ Sex _____ Ht. _____ Wt. _____

Home address __________

Home telephone number __________ Whom may we thank for referring you? __________

MOTHER'S INFORMATION

Name __________

Address __________

Social Security # __________

Occupation __________

Home Phone # __________

Work Phone # __________

Cell Phone # __________

Do you have dental insurance? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Employee Name __________ DOB __________

Employer __________

Insurance Company __________

Insurance Co. Address __________

Group # __________ ID# __________

FATHER'S INFORMATION

Name __________

Address __________

Social Security # __________

Occupation __________

Home Phone # __________

Work Phone # __________

Cell Phone # __________

Do you have dental insurance? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Employee Name __________ DOB __________

Employer __________

Insurance Company __________

Insurance Co. Address __________

Group # __________ ID# __________

DENTAL HISTORY

Why is the patient seeking dental treatment? (i.e. Checkup, decay, toothaches, trauma, orthodontics)

____

Has the patient ever had a negative or unpleasant experience in the dental or medical office? Please describe.

____

Name of previous dentist(s) __________

Has the patient ever had:

- ☐ TMJ problems
- ☐ Toothaches
- ☐ Tooth grinding or clenching
- ☐ Tooth abscess
- ☐ Injuries to the mouth or teeth
- ☐ Headaches
- ☐ Family history of lots of tooth decay
- ☐ Finger or thumb sucking or other oral habits

At what age was breast or bottle feeding stopped? __________

Who is responsible for brushing the child's teeth? __________

Is the child receiving fluoride in water, toothpaste or a supplement? __________

How do you think your child will tolerate dental treatment? __________

Is there any other dental information we should know? __________

Does the patient like to eat gummy candy, fruit snacks or dried fruit? __________

What does the patient like to drink? __________

MEDICAL HISTORY

Has the patient had any hospitalizations or surgeries? ☐Y ☐N

Is the patient taking any medications at this time? ☐Y ☐N

Were there any problems during pregnancy, birth or the first year of life? ☐Y ☐N

Patient's pediatrician: ______________________________ Phone # ______________

Does the patient have a drug allergy to:

Y	N		Y	N		Y	N	
☐	☐	penicillin	☐	☐	cephalosporins, keflex	☐	☐	amoxicillin
☐	☐	codiene	☐	☐	erythromycin	☐	☐	augmentin
☐	☐	sulfa drugs	☐	☐	acetaminaphen	☐	☐	other

Does the patient have a history of:

Y	N		Y	N	
☐	☐	osteoporosis	☐	☐	speech problems
☐	☐	allergies	☐	☐	behavior problems
☐	☐	heart murmur	☐	☐	hearing problems
☐	☐	congenital heart problems	☐	☐	fainting
☐	☐	asthma	☐	☐	diabetes
☐	☐	Rheumatic fever	☐	☐	Tuberculosis (TB)
☐	☐	epilepsy or seizures	☐	☐	kidney disease
☐	☐	implants	☐	☐	liver disease
☐	☐	prosthetic valves or devices	☐	☐	hepatitis
☐	☐	in-dwelling vascular catheters	☐	☐	birth defects or genetic disorders
☐	☐	bleeding problems	☐	☐	cancer or tumors
☐	☐	sickle cell disease or trait	☐	☐	HIV or HepB virus
☐	☐	shunts	☐	☐	any other problems not listed
☐	☐	ear infections			

Has the patient ever taken any bisphosphonate medications (osteoporosis or cancer drugs)? Yes ☐ No ☐

Female patients:
Has mensturation begun? Yes ☐ No ☐
Does the patient use oral contraceptives? Yes ☐ No ☐

CONSENT FOR TREATMENT

I, being the (circle your relationship to patient) mother, father, guardian of ________________ hereby give my consent to Dr. Gehrke and staff to perform such treatments, services, medications, anesthesia and accepted behavior management techniques that may be necessary to correct any oral infection, infectious disease, abnormality or deficiency. I am advised that though good results are expected, the possibility and nature of complications cannot always be accurately anticipated and that, therefore, there can be no guarantee, expressed or implied either as to the result of treatment or as to cure.

I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered to my satisfaction. I also state that I am responsible for patient's accounts. Fees are due and payable at the time services are rendered unless prior financial arrangements have been made. Any payments received by the doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a finance charge may be added to any overdue balance .

____

Signature of consenting party date Signature of dentist date