DENTAL WELLNESS OF BEND

Child New Patient Form

First Name: _____ **Last Name**:_____ **Age**: ____ **Birthdate**: ___/____/_____

Gender: M / F **Grade**: _____ **School**: _____ **Favorite interests/ Hobbies**: _____
_____

What are your chief concerns regarding your child's appointment today?
_____
_____

Guardian/ Parent

Name: _____ **Birthdate**: ___/____/_____
Social security #____-____-_____ **Address**: _____
_____
Home phone: ____-____-_____ **Cell phone:** ____-____-_____ **Email address:**_____
_____ **Insurance Provider:** _____ **Policy #** _____

Medical History

Physician: _____ **Date of last visit**: _____
Address: _____ **Phone**: _____
Please select Yes or No. (If yes please fill in details)
☐Yes ☐ No Is your child taking any medications? _____
☐Yes ☐ No Is your child allergic to any medication?_____
☐Yes ☐ No Does your child have a history of a major illness? _____
☐Yes ☐ No Has your child had any major operations? _____
☐Yes ☐ No Has your child ever been involved in a serious accident?_____
Is there a medical condition we have not discussed that you feel we should be aware of?_____
_____

Dental History

☐Yes ☐ No Does your child have a history of cavities?_____
☐Yes ☐ No Is there anything about your child's teeth that is of immediate concern?_____
☐Yes ☐ No Has your child ever had an injury to the face, mouth, or teeth?_____
☐Yes ☐ No Is your child currently experiencing any dental pain or sore teeth?_____
☐Yes ☐ No Does your child have speech problems?
_____

Please note any other specific concerns about your child's dental health. _____
_____