New Child Patient Form

Child / Minor Information

Name of Child/Minor: _____ SS#: _____
Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ Cell Phone: _____
Sex: ☐ M ☐ F Age: _____ Birth Date: _____
School Name: _____
Person Financially Responsible: _____
Parent's email for communication:_____
How did you hear about our office?: _____

Dental Insurance / Parent Information

Father's Name: _____	Mother's Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number:_____
☐ S ☐ M ☐ D	☐ S ☐ M ☐ D
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____
SS#: _____	SS#: _____
Birth Date: _____	Birth Date: _____
Email: _____	Email: _____
Do you have Dental Insurance Coverage for the Child/Minor?: ☐ Y ☐ N	Do you have Dental Insurance Coverage for the Child/Minor?: ☐ Y ☐ N

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Alderman all Insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-name dentist may use my health care information and disclose such information to the above-named insurance company and their agents for the purpose obtaining payments for services and determining insurance benefits of the benefits payable for release services. This consent will end when my current treatment plan is complete or one year from the date signed below.

Signature of Parent/ Guardian: _____

Health History

Physician's Name: _____ Date of last visit: _____

Please indicate if your child **has** or **had** any of the following:

- ☐ AIDS/HIV
- ☐ Allergy
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy or Convulsions
- ☐ Fainting Spells/Seizures
- ☐ Family History of Malignant Hyperthermia
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Heart Defeat or Murmur
- ☐ High Blood Pressure
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Herpes
- ☐ Heart Trouble/Attack
- ☐ Immune System Disorder
- ☐ Kidney Trouble
- ☐ Prolapsed Mitral Valve
- ☐ Radiation Treatment
- ☐ Rheumatic Heart Disease
- ☐ Pacemaker
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Taken Cortisone in Past
- ☐ Year Tuberculosis
- ☐ Ulcers

Do you smoke? ☐ Yes ☐ No Have you taken bisphosphonate drugs? ☐ Yes ☐ No

Other: _____

Medications:
List any medications your child may currently be taking and the correlating diagnosis:

_____
_____
_____
_____

Allergies:

- ☐ Aspirin
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Acrylic
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Metals

Other allergies: _____
_____

Woman:

Are you pregnant? ☐ Yes ☐ No Due Date: _____
Are you nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No
Is there anything else we should know? _____
Please let us know if you would like a copy of Notice of Privacy Practices HIPAA that is offered to all of our patients.
Please list any other person(s) that have permission to access your records and account information:
_____

We are pleased to welcome you to our practice! _____
Signature of patient or parent/guardian