Kissimmee Childrens Dentistry

595 Oak Commons Boulevard, Suite C
Kissimmee, FL 34741

New Patient Information Form

Patient's name ______________________________ Today's Date ______________
First Middle Last

Address ______________________ City ______________ State ________ Zip ________

Birthdate ______________ Male or Female

Home phone ______________ Cell phone ______________

If student; name of school ______________________ City ______________ State ________

Mother's name ______________________ Birthdate ______________________

Mother's employer ______________________ Work phone ______________

Father 's name ______________________ Birthdate ______________________

Father's employer ______________________ Work phone ______________

Whom may w e thank for referring you ______________________________

Person to contact in case of an emergency (other than parent) ______________ Relationship ______________

Phone ______________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ______________

Address ______________________ Home phone ______________

Driver's license # ______________ Birth Date ______________ Soc. Security # ______________

Email Address: ______________________________

Insurance Information

Name of insured ______________________ Relationship to patient ______________

Birthdate ______________ Soc. Security # ______________ Date employed ______________

Name of employer ______________________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________________ Tel. # ______________

Group # ______________ ID#/Policy # ______________

X______________________________ X______________________________
Name of Parent **Signature of Parent**

Medical History

Pediatrician ____ Date of Last Visit ____________________________

Address ____ Phone ____________________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? Please list: ____
____
Yes No Are you allergic to any medication? ____
Yes No Do you have a history of a major illness? ____
Yes No Have you had any operations or been hospitalized? ____

Type of Surgery: ______________________________Date: _______________________________________
Type of Surgery: ______________________________Date:_______________________________________

Yes No Have you ever had a serious head or neck injury? ____
Yes No Are you on a special diet? ____

Female Patients Only:
Yes No Are you pregnant? ____
Yes No Are you taking oral contraceptives?____
Yes No Nursing?

Circle any of the medical conditions below that you have had or currently have:

Aids/HIV positive
Abnormal bleeding/Hemophilia
ADHD/ADD
Allergic Rhinitis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve/Joint
Asperger's Syndrome
Asthma
Autism Spectrum Disorder
Blood Disease
Blood Transfusion
Breathing Problem(s)
Bone Disorders
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Congenital Heart Defect
Convulsions
Diabetes
Dizziness
Down Syndrome
Yellow Jaundice
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Headaches
Gastrointestinal Disorders
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Pneumonia
Radiation/Chemotherapy
Recent Weight Loss
Rheumatic Fever
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling Limbs
Tonsilitis
Tuberculosis
Tumors/Growths
Ulcers
Venereal Disease

Are there any medical conditions or serious illnesses, not listed above, that you feel we should be aware of? _____________

____

____

Dental History

Previous Dentist Name: ___________________________________ Phone number: ____________________________

Date of last visit: ____

Yes No Is your child presently in any dental pain? Explain: ____

____

Yes No Does your child require antibiotics prior to dental treatment?_____________________________________

Does or did the child have any of the following habits? Check all that apply

Thumb or Tongue habit	Yes	or	No
Mouth Breather	Yes	or	No
Chewing on objects	Yes	or	No
Breast Fed	Yes	or	No
Pacifier	Yes	or	No
Nail Biting	Yes	or	No
Bottle habits	Yes	or	No
Speech Problems	Yes	or	No
Tongue or Cheek Biting	Yes	or	No
Clenching or Grinding	Yes	or	No
Bleeding Gums	Yes	or	No
Other (Please Specify)			

Please check all that apply to your child:

Brushes Daily: Yes or No If not, does your child brush weekly: Yes or No

Flosses Daily: Yes or No If not, does your child floss weekly: Yes or No

If neither apply, how often does your child brush: ____

If neither apply, how often does your child floss: ____

Parent brushes and flosses child's teeth: Yes or No

Yes No Have there been any injuries to face, mouth, or teeth? ____

Yes No Have you ever seen an orthodontist? If yes, who and when? ____________________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____________________

Yes No Are you aware of your jaw clicking or popping?____

Yes No Are you aware of clenching your teeth during the day? ____

Yes No Have you ever been told that you grind your teeth? ____

Yes No Do you have "tension" headaches? ____

Yes No Have you ever experienced chronic ringing in your ears? ______________________________________

Signature:____ Date:___________________