ADAMS
PEDIATRIC DENTISTRY

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NEW PATIENT FORM

Patient Health History

These questions are of great value in aiding us to a better understanding of your child.

Child's Name: ______________________________ Nickname, if any: __________________ Sex: ☐ M ☐ F
Age: ________ Birthday: ____________________ Place of Birth: ____________________
Attends Which School: ____ Grade: ________
Name and Ages of Brothers: ____
Name and Ages of Sisters: ____
Child's Physician or Pediatrician: ______________________________ Date of Last Visit: ________
Family Dentist: ______________________________ Referred by Whom: ________________
Purpose of Visit Today: ________________________ Name of Child's Pet or Hobbies: ________________
Patient's SSN: ________________

Is your child in good health? ☐ Yes ☐ No
Does your child have regular medical exams? ☐ Yes ☐ No
Is your child up to date with immunizations? ☐ Yes ☐ No
Is this your child's first dental visit? ☐ Yes ☐ No
Date of last visit: ____________________
Is your child a thumb sucker? ☐ Yes ☐ No
Use a pacifier? ☐ Yes ☐ No
If your child was bottle-fed, at what age was it discontinued? __
Is your child presently taking any medication? ☐ Yes ☐ No
Medications: ______________________
Does your child have any allergies to medication? ☐ Yes ☐ No
Medications: ______________________
Is your child presently undergoing medical treatment? ☐ Yes ☐ No
Has your child ever had an unfavorable experience in a dental office? ☐ Yes ☐ No
Does your child have a toothache? ☐ Yes ☐ No
Is your child adopted? ☐ Yes ☐ No
Has your child ever had general anesthesia? ☐ Yes ☐ No

Check all that apply to your child:

☐ Seasonal Allergies	☐ Versed Allergy
☐ Asthma	☐ Allergic to ________
☐ Emotional Disorder	☐ Hearing Disorder
☐ Liver Disorder	☐ Mental Disorder
☐ Nerve Disorder	☐ Sensory Disorder
☐ Speech Disorder	☐ Vision Disorder
☐ Anemia	☐ Sickle Cell Anemia
☐ Heart Condition	☐ Kidney Disease
☐ Respiratory Problems	☐ Brain Injury
☐ Mental Retardation	☐ Epilepsy/Seizures
☐ Spina Bifida	☐ Autism
☐ ADD/ADHD	☐ Asperger's
☐ Down Syndrome	☐ Cerebral Palsy
☐ Cleft Lip/Palate	☐ Wheelchair Bound
☐ Tuberculosis	☐ Hepatitis
☐ Diabetes	☐ Cancer ________
☐ Pregnancy	☐ Other ________

Father: ______________________________ DOB: ________________ SSN: ________________
First Middle Last
Mother: ______________________________ DOB: ________________ SSN: ________________
First Middle Last
Home Address: ____ Phone: ________________
Street City State Zip
Father Employed: ________________________________ Cell Phone: ________________
Business Address ________________________________ Marital Status: ________________
Mother Employed: ________________________________ Cell Phone: ________________
Business Address ________________________________ Marital Status: ________________
Person to contact locally in case of emergency, other than parents:________________Phone: ________________

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any/or all necessary dental service can be started and accomplished by Dr. Adams Jr and/or Dr. Seaton.
Authorization is hereby granted as such; furthermore, I will be responsible for any bill incurred on this child for dental treatment. Person responsible for the account: ______________________________(must be present at first visit)
I authorize and request my insurance company to pay directly to the dentist those insurance benefits otherwise payable to me.
Name of Dental Insurance: ____
Signature: ____ Date: ________________