WESTCHESTER
pediatric dentistry
www.wcpediatricdentist.com

New Patient Form

Date:______/______/______

Tell us about your child

Child's Name: ____________________
Nickname: ____________ Male ☐ Female ☐
Child's Birthdate: ______/______/______ Child's age: __________
School: ____________ Grade: __________
Child's Home Number: ____________ SSN: __________
Child's Home Address: ____________________
E-Mail address: ____________________

Who is accompanying the child today?

Name: ____________ Relationship: __________
Do you have legal custody of child? Yes ☐ No ☐
Who may we thank for referring you? ____________________
Other family members seen by us: ____________________

____
Previous/present dentist: ____________________
Last visit date: ______/______/______

Mother's information

Name: Ms. ☐ Mrs. ☐ Dr. ☐ ____________________
Work Number: __________ Ext: ______ Home Number: __________
Cell Number: __________ Employer: __________
SSN: ____________________

Father's information

Name: Mr. ☐ Dr. ☐ ____________________
Work Number: __________ Ext: ______ Home Number: __________
Cell Number: __________ Employer: __________
SSN: ____________________

Person responsible for account

Name: ____________ Relation: __________
Billing Address: ____________________

Work Number: __________ Ext: ______ Home Number: __________
Employer: ____________________
SSN: ____________________

Why did you bring the child to the dentist today?

____

Has the child ever had a serious/difficult problem associated with previous dental work? Yes ☐ No ☐
Is the child's water fluoridated? Yes ☐ No ☐
Is the child taking fluoride supplements? Yes ☐ No ☐
Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD) Yes ☐ No ☐
Does the child brush his/her teeth daily? Yes ☐ No ☐
Floss his/her teeth daily? Yes ☐ No ☐
Child's Physician: ______________________________
Phone Number: ____________________ Date of last visit:_____/_____/_____
Is the child currently under the care of a physician? Yes ☐ No ☐
Please describe the child's current physical health: Good ☐ Fair ☐ Poor ☐
Has the child ever had any of the following medical problems?

Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐	Congenital heart defect
Yes ☐	No ☐	Cancer	Yes ☐	No ☐	Convulsions/Epilepsy
Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Abnormal bleeding
Yes ☐	No ☐	Rheumatic fever	Yes ☐	No ☐	Hearing Impairment
Yes ☐	No ☐	HIV+/AIDS	Yes ☐	No ☐	Any operations
Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐	Any stays in hospital
Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Kidney/Liver problems
Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Handicap/Disabilities
Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐	Allergies to any drug

Please discuss any problems that the child has had:

____

____

Has your child received regular six-month dental care? Yes ☐ No ☐ N/A ☐

Does the child have any of the following habits?
Yes ☐ No ☐ Thumb/finger sucking
Yes ☐ No ☐ Lip sucking/biting
Yes ☐ No ☐ Nail biting
Yes ☐ No ☐ Nursing bottle habits

I authorize the dental staff to perform the necessary dental services my child may need. The information given is correct to the best of my knowledge, and I understand that this information will be held in the strictest of confidence.
I understand that it is my responsibility to inform this office of any changes in my child's health status.

Signature of parent or guardian ______________________________