Children's Dentistry of Kyle
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New Patient Forms

Child's Information:

Last name: _____ First: _____ Middle: _____

Preferred Name: _____ Gender (Please circle): M F

Date of Birth: _____ Age: _____ SSN: _____

Child's Physician/Office name: _____ Phone#: _____

Parent Information:

Mother's name: _____ DOB:_____ SSN: _____

Address/City/State/Zip: _____

Home#: _____ Cell#: _____ Work#:_____

Employer: _____ E-mail: _____

Father's name: _____ DOB: _____ SSN: _____

Address/City/State/Zip: _____

Home#: _____ Cell#: _____ Work#: _____

Employer: _____ E-mail: _____

How did you hear from us? Internet: ____ Drive by: ___ Tooth Fairy Program:___
Family/Friend Name: _____ Referral from: _____
Other (Please Specify):_____

DO YOU HAVE A YELP ACCOUNT? (Please circle) **YES** NO
☺ We would love to hear about your experience in our office ☺

EMERGENCY CONTACT (not living with you):

Name: _____ Relationship: _____ Phone#: _____

NAME: _____

Please describe your child's oral health: Good ____ Fair ____ Poor ____
Does your child brush teeth daily? Yes ___ No ___
Floss daily? Yes ___ No ___

Has your child had a serious/difficult problem associated with dental work? Yes __No__
Has your child ever had any pain or tenderness in the jaw joint (TMJ/TMD?) Yes__ No__
Does your child have any oral habits? NO_____

YES_____ Thumb sucking/Finger sucking _____
Lip sucking _____
Nail biting _____
Bottle Feed _____
Nursing _____
Other (please specify) _____
_____

Has your child ever had any of the following medical problems?

Heart Murmur _____	**Cancer** ____	**Prosthesis** ____
Asthma _____	**Diabetes** ____	**Convulsions/Epilepsy** ___
Rheum. Fever _____	**HIV+/AIDS** ____	**Abnormal Bleeding** ___
Congenital Heart Def. ____	**Hemophilia** ___	**Hearing Impairment** ___
Latex Allergy _____	**Hepatitis** ___	**Kidney/Liver Problems** ___
	Tuberculosis ___	**Handicaps/Disabilities** ___

Allergy to any drugs: NO____ YES____ (Please list)_____
_____

History of Scarlet Fever: NO____ YES____ (If, so when)_____

Please list all prescription and nonprescription medications your child is currently taking:_____
_____

Has your child had any operations or stays in hospital: NO _____ YES _____
If so, please explain: _____
_____

Is your child under the care of a Physician? NO _____ YES _____
If so, please explain: _____

Please note any serious medical problems that your child has had:
_____
_____

Since _____ is a minor child, it is necessary to obtain signature of the parental guardian who is responsible for any outstanding balances and/or fees not covered by dental insurances and giving permission before any necessary dental services can be performed. Authorization is hereby granted.

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____