THIS FORM IS FOR NEW PATIENTS ONLY – *WELCOME TO OUR OFFICE.* ***Please print carefully***

Child's Name _____ M ☐ F ☐ Nickname _____
Last First

Parent or Guardian _____
Father Mother

Home Address _____
Street P.O. Box Town State Zip

Home Phone (____)_____ Work Phone: Mother's (____) _____ Father's (____) _____

Email _____ Cell Phone: Mother's (____) _____ Father's (____) _____

Who is the Child's LEGAL GUARDIAN if different from above? _____
Name

_____
Street P.O. Box Town State Zip

Dental Insurance &/or Medical HMO - ***Please list ALL Dental Plans as well as Medical HMO Coverage that your family has.***

Dental Insurance or Medical HMO _____ Dental Insurance or Medical HMO _____

Effective Date _____ Effective Date _____

Subscriber _____ Subscriber _____

Subscriber's Date of Birth _____ Subscriber's Date of Birth _____

(When more than one insurance, Dates of Birth and Effective Dates dictate the order of submittance)

Subscriber # _____ / Group# _____ Subscriber # _____ / Group # _____

Employer _____ Employer _____

Please list the names & years of birth of your other children in this practice: _____

_____

Child's School _____ Referred By _____

In Case of Emergency (relative or friend):

Contact Name _____ **Emergency Contact Phone #** (____) _____

MEDICAL HISTORY

Child's Date of Birth _____ Child's Physician _____

Is the child adopted? Yes ☐ No ☐ Is the child in good health? _____

Does the child have special needs? Explain _____

Is the child under a physician's care now? _____ If so, please give reason for treatment _____

_____

Name any medication the child is taking at this time *(including fluoride)* and the reason for taking it: _____

_____

Please circle any illness the child has ever had:

Allergies	Epilepsy	Prolonged Bleeding	Seizures	Other:
Rheumatic Fever	Anemia	Jaundice	Sickle Cell Disease or Trait	_____
Infectious Hepatitis	Heart Trouble	Learning Disabilities	Cystic Fibrosis	
Reactions to Drugs or Anesthetics	Glaucoma	Emotional Disorders	Leukemia or Tumors	_____
Tuberculosis	Kidney or Liver Disease	Hearing Loss	Cerebral Palsy	
Diabetes	Asthma	Speech Problems	HIV/AIDS	_____

Is there any other information that should be known about the Child's Health? _____

About Previous Dental Visits? _____

Reason for this visit _____

Father's S.S.# _____ Mother's S.S.# _____

Date _____

Dentist's Signature: _____

By signing below, you:
① indicate your understanding that any amounts not covered by insurance are your responsibility;
② authorize release of any information relating to insurance claims we submit on your behalf; and
③ authorize payment of insurance benefits to Norwell Pediatric Dentistry, L.L.C.

SIGNATURE _____ **TODAY'S DATE** _____

Please complete other side →