**PEDIATRIC**
**NEW PATIENT FORM**


190 Curtis Pkwy NE B,
Calhoun, GA 30701
**706.602.0448**

## 1. Tell Us About Your Child

Child's Name _____ Nick name _____

Date of Birth _____ Age _____ Sex _____ Male _____ Female

Siblings we treat _____

Home address _____

City/State/Zip _____

Phone # _____ School _____ Grade _____

## 2. Mother's Information

Mother's Name _____ ❒ Step Mother ❒ Guardian

Date of Birth _____

Employer _____ Work # _____

Home # _____ Cell # _____ Allow Text Alerts? ❒ Yes ❒ No

Driver's License # _____ ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

## 3. Father's Information

Father's Name _____ ❒ Step Father ❒ Guardian

Date of Birth _____

Employer _____ Work # _____

Home # _____ Cell # _____ Allow Text Alerts? ❒ Yes ❒ No

Driver's License # _____ ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

## 4. Person Responsible For Account

Name _____ Relationship _____

Home # _____ Work # _____

Billing Address _____ City/State/Zip _____

## 5. People Authorized To Bring Child To Appointments

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

## 6. Primary Dental Insurance

Insurance Co. Name _____

Ins Co. Address _____

Ins Co. Phone # _____

Group # (plan, local, or policy #) _____

Policy Holder's Name _____

Relationship to Patient _____

Date of Birth _____

Policy Holder's Employer _____

## 7. Secondary Dental Insurance

Insurance Co. Name _____

Ins Co. Address _____

Ins Co. Phone # _____

Group # (plan, local, or policy #) _____

Policy Holder's Name _____

Relationship to Patient _____

Date of Birth _____

Policy Holder's Employer _____

## MEDICAL AND DENTAL HISTORY

Child's Physician _____ Phone # _____

Address _____

Is the child currently under the care of a physician? _____ Yes _____ No

If yes, please explain

_____

_____

Please describe the child's current physical health: ❒ Good ❒ Fair ❒ Poor

Are Immunization's Current? ❒ Yes ❒ No

Please list all medications that the child is currently taking.

_____

_____

**Medical History** - Has your child ever been treated for:

| | | | |
|---|---|---|---|
| ADD/ADHD | ❒ Yes ❒ No | Head Injury | ❒ Yes ❒ No |
| Anemia | ❒ Yes ❒ No | Heart Disease | ❒ Yes ❒ No |
| Anxiety Disorder | ❒ Yes ❒ No | Hepatitis Type ____ | ❒ Yes ❒ No |
| AIDS / HIV | ❒ Yes ❒ No | High Blood Pressure | ❒ Yes ❒ No |
| Tuberculosis | ❒ Yes ❒ No | Kidney / Bladder / UTI | ❒ Yes ❒ No |
| Cancer | ❒ Yes ❒ No | Depression | ❒ Yes ❒ No |
| Eye Problems | ❒ Yes ❒ No | Migraine Headaches | ❒ Yes ❒ No |
| Diabetes | ❒ Yes ❒ No | Menstrual Disorders | ❒ Yes ❒ No |
| Dizziness / fainting | ❒ Yes ❒ No | Mononucleosis | ❒ Yes ❒ No |
| ENT Disorder | ❒ Yes ❒ No | Hemophilia Type ____ | ❒ Yes ❒ No |
| Cerebral Palsy | ❒ Yes ❒ No | Recent Weight Loss | ❒ Yes ❒ No |
| Hearing / Speech | ❒ Yes ❒ No | Sickle Cell | ❒ Yes ❒ No |
| Kidney Problems | ❒ Yes ❒ No | Heart Murmur | ❒ Yes ❒ No |
| Hives | ❒ Yes ❒ No | Blood Transfusion | ❒ Yes ❒ No |
| Liver Problems | ❒ Yes ❒ No | Cleft Palate | ❒ Yes ❒ No |
| Scarlet Fever | ❒ Yes ❒ No | Rheumatic Fever | ❒ Yes ❒ No |
| Handicaps / Disabilities | ❒ Yes ❒ No | Autism | ❒ Yes ❒ No |

## DENTAL HISTORY

| | | | |
|---|---|---|---|
| Gum Infection | ❒ Yes ❒ No | Sensitive Teeth | ❒ Yes ❒ No |
| Color of Teeth | ❒ Yes ❒ No | Tooth Alignment | ❒ Yes ❒ No |
| Thumb Sucking | ❒ Yes ❒ No | Cavities / Toothache | ❒ Yes ❒ No |
| Does he/she brush their own teeth? | ❒ Yes ❒ No | Does he/she use fluoride toothpaste? | |
| Does he/she floss their own teeth? | ❒ Yes ❒ No | | ❒ Yes ❒ No |
| Was he/she breast or bottle fed? | | Does he/she go to bed with a bottle? | |
| ❒ Breast ❒ Bottle | | ❒ Yes ❒ No Date Stopped: _____ | |

Allergies

_____

_____

Surgeries

_____

_____