NEW PATIENT RECORD

Today's Date: _____

Child's Name _____ Sex: M F Age _____ Birthdate _____

Residence - Street _____ City _____ State _____ Zip _____

Father's Name _____ Phone - Home _____ Phone - Cell _____

Residence - Street _____ City _____ State _____ Zip _____

Mother's Name _____ Phone - Home _____ Phone - Cell _____

Residence - Street _____ City _____ State _____ Zip _____

Parents' Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Father Employed By _____ Present Position _____ How Long Held _____

Father's Social Security # _____ Father's Birthdate _____ Phone - Business _____

Mother Employed By _____ Present Position _____ How Long Held _____

Mother's Social Security # _____ Mother's Birthdate _____ Phone - Business _____

May We Call You At Work? Yes _____ No _____

Person Responsible For This Account _____ Social Security # _____

Do You Have Dental Insurance? Yes _____ No _____ Name of Insurance Company _____

Referred By _____ Number of Children In Your Family _____

DENTAL HISTORY

Is this child's first visit to a dentist? Yes _____ No _____

If not, how long since last visit? _____

How long since last cleaning and fluoride treatment? _____

Is your drinking water fluoridated? Yes _____ No _____

Do you drink bottled water? Yes _____ No _____

If yes, what brand? _____

Have any cavities been noted in past? Yes _____ No _____

Purpose of today's visit _____

Has child had any unfavorable dental experiences? Yes _____ No _____

Is child having dental pain or toothache at this time? Yes _____ No _____

Have any teeth (baby or permanent) been removed by extraction? Yes _____ No _____

Was it suggested that the space be maintained? Yes _____ No _____

Has Orthodontics ever been suggested? Yes _____ No _____

Have there been any injuries to teeth - blows, falls, chips, etc.? Yes _____ No _____

MEDICAL HISTORY

Is child in good health? Yes _____ No _____

Name of Physician _____

Has child ever been hospitalized? Yes _____ No _____

If Yes, When _____

Has child had surgery? Yes _____ No _____

If Yes, When _____

Is surgery contemplated? Yes _____ No _____

Is child subject to profuse bleeding? Yes _____ No _____

Is child allergic to penicillin? Yes _____ No _____

or other drugs? Yes _____ No _____

If yes _____

Is child receiving any medication? Yes _____ No _____

If yes _____

Has child ever required a blood transfusion? Yes _____ No _____

Has child had history of diabetes? Yes _____ No _____

. . . seizures? Yes _____ No _____

. . . heart trouble or heart murmur? Yes _____ No _____

If yes, antibiotic required? Yes _____ No _____

. . . hepatitis? Yes _____ No _____

. . . asthma? Yes _____ No _____

. . . AIDS? Yes _____ No _____

. . . kidney infection? Yes _____ No _____

. . . rheumatic fever? Yes _____ No _____

. . . any other problems? Yes _____ No _____

Does your child have a physical or mental handicap? Yes _____ No _____ If yes, please explain: _____

Does your child have a learning disability? Yes _____ No _____ If yes, please explain: _____

Is your child enrolled in special education classes? Yes _____ No _____

CONSENT TO TREAT

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change in my child's health or medications, I will inform the Doctor at the next appointment. I hereby give consent to Drs. Ewald, Wrobel and staff to treat the dental needs of my child.

I understand that I am responsible for all charges made on my account. If additional steps must be taken to collect my account I will pay all costs including collection agency fees, court costs and attorney's fees. If I have any questions regarding my account I will call the office at (815) 434-6447.

_____

Parent or Legal Guardian's Signature