White Oak Pediatric Dentistry

New Patient Information

Patient Information

Child's Name: _____ Home Address:
Nickname: _____ Street: _____
Date of Birth: _____ City: _____
Age: _____ State: _____
Gender: _____ Zip Code: _____
Child's SSN: _____
Child's School/Daycare: _____
Who brought the child today?: _____
Are you the child's legal Guardian? YES NO
If no, list the legal Guardian(s) here: _____

Legal Guardian Information:
Name: _____
Date of Birth: _____
Relation to child: _____
SSN: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Email: _____
Employer: _____
Occupation: _____

Legal Guardian Information:
Name: _____
Date of Birth: _____
Relation to child: _____
SSN: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Email: _____
Employer: _____
Occupation: _____

Consent for Phone, Text, and Email Notifications: YES NO

Primary Dental Insurance

Insurance Company: _____ Subscriber information:
Address: _____ Name: _____
Phone number: _____ DOB: _____
Group #: _____ SSN: _____
ID #: _____ Address: _____
Employer: _____

Social Information:

Child's special interests: _____
Additional information we should be aware of: _____

Dental Information:

Why did you bring your child today? _____
Is this your child's first dental visit? _____
If no, please list previous provider: _____
Why did you choose to switch providers? _____
Has your child been experiencing any dental pain? YES NO
If yes, please specify: _____
Has your child experienced any major injuries to their face, mouth or teeth?
_____
Do you believe your child will be cooperative? **YES** **NO**
If no, please explain: _____
How often does your child brush? _____
How often does your child floss? _____
Does your child use Fluoride toothpaste? YES NO
Does your child take Fluoride supplements? YES NO

Due to the patient being a minor, we must obtain signed permission from a GUARDIAN before dental care can be rendered. As the person bringing the child to the visit, I am acting as his/her guardian at this time. I authorize White Oak Pediatric Dentistry to perform appropriate preventative and therapeutic services for this child in accordance with accepted standards of pediatric dental care. The information I have given is correct, to the best of my knowledge. I am aware that it will be held in strict confidence and that it is my responsibility to inform the office of any changes in the child's medical status moving forward.

Guardian's Name: _____Guardian's Signature: _____ Date: _____