

New Patient Intake Form

Patient Health Information

Child's First Name -	Nickname if any -	Child's Last Name -
Child's Date of Birth -	Child's Gender -	
Does your child have (have they had), any of the following conditions?		
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Endocrine Disorders	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Measles	<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Pervasive Developmental Disorders(PDD)	<input type="checkbox"/> Speech Disorders	<input type="checkbox"/> Congenital Birth Defect
<input type="checkbox"/> Other condition not listed	<input type="checkbox"/> None of the Above	
List condition, if not listed: -	Is your child up to date with their immunizations? -	Is your child taking any medications? -
If yes, please type name of medication and why they are taking it: -	Has your child ever had a reaction to any medication, such as penicillin, aspirin? -	What type of reaction? -
Has your child ever been a patient in the hospital or emergency room? -	If yes, please explain: -	Does your child have any emotional, mental or nervous issues? If so, please explain -
Is your child allergic to any of the following?		
<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Pollen	<input type="checkbox"/> Other, not listed
<input type="checkbox"/> Penicillin		<input type="checkbox"/> No Known Allergies
If other not listed, indicate allergy: -	Has either parent or sibling(s) ever had any of the following? -	If yes to any condition listed, please indicate which family member & date of diagnosis: -
Name of Pediatrician -	Name of Pharmacy -	Pharmacy Phone Number -
Who can we thank for referring you to our office? -	Reason for today's visit (1st Examination, Check-up, Toothache, etc.) -	How long since last visit to dentist? -
Was your child's last dental experience pleasant or unpleasant? -	Does your child object to anything in particular? Please indicate what: -	

Dental Insurance Information

DENTAL INSURANCE CARD (PLEASE TAKE A PHOTO) IF PHOTO TAKEN, YOU DON'T NEED TO COMPLETE SOME INFORMATION LISTED BELOW (Front)

DENTAL INSURANCE CARD (PLEASE TAKE A PHOTO) IF PHOTO TAKEN, YOU DON'T NEED TO COMPLETE SOME INFORMATION LISTED BELOW (Back)

Policy Holder Name -	Policy Holder's birthdate -	Policyholder's Employer Name -
Insurance Company Name -	Insurance Company Street Address -	Insurance Company Street Address 2 -
Insurance Company City -	Insurance Company State -	Insurance Company ZIP Code -
ID# on card -	Group # -	Relationship to Patient -

If there is another dental plan that your child is covered under, please take a photo of both sides of the card. If the information is on the photo of the card itself, you don't need to type it in.

Secondary Dental Insurance Coverage (if applicable) (Front)

Secondary Dental Insurance Coverage (if applicable) (Back)

Secondary Insurance Company Street Address -	Secondary Insurance Company City -	Relationship to Patient -
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Authorization to Release Information: I hereby authorize the above named dentist(s) to provide any insurance company(s), claims administrative(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits. I am aware that I am financially responsible for any charges not covered by my insurance carrier.
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PAYMENTS

If you would like to leave a Credit Card/HSA card on File For Coinsurance Amounts or amounts not covered by insurance.

Card Holder Name -	Card Number -	Expiry Date -	Security Code ***
Country -			

E-Signature (draw, upload or type) (ESign)

Date :

Financial Responsibility

Name of Parent/Guardian Responsible for Payment (first & last name): -	Date of Birth -	Social Security Number -
Street Address -	Street Address 2 -	City -
State -	Zip Code -	Email address: -
Cell Phone #: -		

By providing your cell phone number, you authorize Milestones Pediatric Dentistry to send text messages regarding your child's dental health, billing, insurance & other dental related information. Message & Data rates may apply (check with your carrier) You can opt out at any time by typing STOP after receiving a message from us.

Name of Parent/Guardian #2 (first & last name):

Date of Birth (if unknown type in 01/01/1900)

address - IF SAME, WRITE IN SAME

City

State:

Zip Code

Email address

Cell phone#(if unknown, type in 123-456-7891

Which parent/guardian does child live with?

Phone Number to receive Text Messages from our office

Consent for Photos & Media - please choose ONE option

I consent to have my child's photo taken & uploaded to the computer software for Milestones Pediatric Dentistry (for identification purposes) and ALSO for posts to our social media accounts

I consent only for my child's photo to be taken & uploaded for the computer software of Milestones Pediatric Dentistry BUT NOT for any social media postings.

Consent to Receive Text Messages from our office

I consent to receive text messages from Milestones Pediatric Dentistry regarding appointments, billing & information regarding the dental health of my child (children)

I do NOT consent to receiving text messages from Milestones Pediatric Dentistry

E-Signature (draw, upload or type) I consent to signing this document electronically (ESign)

Name of person signing form & relationship to patient (mother, father, legal guardian)

Date :