RON EWERT, DDS, PC
comprehensive family dental care
"We care for your smile"

Child/Young Adult - New Patient Information Form

Today's Date: ______________ Email: ____

Patient Name: ___________________ ___________________ _____ I prefer to be called: ____________ ___ Male ___ Female
Last First MI

Birthdate: _______________ Age: ____ SS #: _____________________________ Hobbies / Sports: ______________________________

Hm #: __________________________ School: ____ Grade: ______

Home Address: ____ _________________________ ________________ ________________
City State Zip

Whom may we *Thank* for referring you? ___________________ Other family members seen by us: ______________________________________

Previous / Present Dentist: _____________________________ Last Visit Date: _______________________________

Who is responsible for making appointments? Name: __________________________ Relation to You: ___________________________________

Work Phone: _________________________ Home Phone: _________________________

Parent Information

Who is accompanying you today? ____ Relationship: _________________________

Does this person have legal custody of you? ___ Yes ___ No

Parent's Marital Status: (Please Check) ___ Single ___ Widowed ___ Married ___ Divorced ___ Separated

Mother's Information: ___ Step Mother ___ Guardian

Name: _________________________ Birthdate: ________________ Wk #: __________________ Ext: ___ Hm #: _______________________

Employer: ____________________________ SS #: ____________________ How Long at Current Job? ______ Job Title: ____________________

Father's Information: ___ Step Father ___ Guardian

Name: _________________________ Birthdate: ________________ Wk #: __________________ Ext: ___ Hm #: ______________________

Employer: ____________________________ SS #: ____________________ How Long at Current Job? ______ Job Title: ____________________

Person Responsible for Account:

Name: _________________________ Relation: ______________ Wk #: __________________ Ext: ___ Hm #: ______________________

Employer: ____________________________ DL #: _______________ SS #: ____________________

Billing Address: ____ ________________________ _______________ ________________
City State Zip

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Primary Dental Insurance

Orthodontic Coverage? ___ Yes ___ No Insurance Co. Name: ______________________________ Insurance Co. Ph #: ____________________

Address: ____ Group # (Plan, Local or Policy #): _______________________________

Policy Owner's Name: ____________________________________ Relationship to Policy Owner: ________________

Policy Owner's Birthdate: _________________ Policy Owner's SS #: ______________________

Policy Owner's Employer: ____

Employer's Address: ____

Secondary Dental Insurance

Orthodontic Coverage? ___ Yes ___ No Insurance Co. Name: ______________________________ Insurance Co. Ph #: ____________________

Address: ____ Group # (Plan, Local or Policy #): _______________________________

Policy Owner's Name: ____________________________________ Relationship to Policy Owner: ________________

Policy Owner's Birthdate: _____________ Policy Owner's SS #: ______________________

Policy Owner's Employer: ____

Employer's Address:

Medical History

Have you ever had any of the following medical problems? (Please check those that apply)

___**Y** ___ **N** **Abnormal Bleeding**
___**Y** ___ **N** **Anemia**
___**Y** ___ **N** **Any Hospital Stays**
___**Y** ___ **N** **Artificial Bones / Joints**
___**Y** ___ **N** **Asthma**
___**Y** ___ **N** **Cancer**
___**Y** ___ **N** **Chicken Pox**
___**Y** ___ **N** **Congenital Heart Defect**
___**Y** ___ **N** **Convulsions / Epilepsy**
___**Y** ___ **N** **Diabetes**
___**Y** ___ **N** **Exposed to HIV, but Neg.**
___**Y** ___ **N** **Handicaps / Disabilities**
___**Y** ___ **N** **Hearing Impairment**
___**Y** ___ **N** **Heart Murmur**
___**Y** ___ **N** **Hemophilia**
___**Y** ___ **N** **Hepatitis**
___**Y** ___ **N** **Hives**
___**Y** ___ **N** **HIV+ / AIDS**
___**Y** ___ **N** **Kidney Problems**
___**Y** ___ **N** **Liver Problems**
___**Y** ___ **N** **Measles**
___**Y** ___ **N** **Mononucleosis**
___**Y** ___ **N** **Mitral Valve Prolapse**
___**Y** ___ **N** **Rheumatic / Scarlet Fever**
___**Y** ___ **N** **Skin Rash**
___**Y** ___ **N** **Tuberculosis (TB)**

Are your immunizations current? ___ Yes ___ No

Are you allergic to any of the following?

___**Y** ___ **N** **Aspirin** ___**Y** ___ **N** **Erythromycin** ___**Y** ___ **N** **Penicillin** ___**Y** ___ **N** **Codeine**
___**Y** ___ **N** **Jewelry / Metals** ___**Y** ___ **N** **Tetracycline** ___**Y** ___ **N** **Latex** ___**Y** ___ **N** **Dental Anesthetics**
___**Y** ___ **N** **Plastic** ___**Y** ___ **N** **Other**

Please list any other allergies that you have: ____
Did / do you have any of the following habits?

___**Y** ___ **N** Nursing Bottle Habits ___**Y** ___ **N** Speech Problems ___**Y** ___ **N** Thumb / Finger Sucking ___**Y** ___ **N** Tongue Thurst
___**Y** ___ **N** Lip Sucking / Biting ___**Y** ___ **N** Mouth Breather ___**Y** ___ **N** Nail Biting ___**Y** ___ **N** Used Pacifier?
___**Y** ___ **N** Clenching / Grinding Teeth

Please discuss any serious medical problems you've experienced: ____
Is there anything you would like to discuss with the doctor in private? ___ Yes ___ No

Dental History

Why have you come to the dentist today? ____

Have you experienced problems with previous dental work? ___ Yes ___ No

Is your water fluoridated? ___ Yes ___ No Are you taking fluoridated supplements? ___ Yes ___ No

Have you ever had any pain / tenderness in your jaw joint (TMJ / TMD)? ___ Yes ___ No

Do you brush your teeth daily? ___ Yes ___ No Floss your teeth daily? ___ Yes ___ No Do your gums bleed? ___ Yes ___ No

Do you require antibiotics before dental work? ___ Yes ___ No

Have you ever taken Phen-Fen (Also known as Redux or Pondimin)? ___ Yes ___ No If yes, when? ________

Are you currently under a physician's care? ___ Yes ___ No Physician's Name: ___________________________ Date of last visit: ____________

Physician's Phone #: ________________________ Please describe your current physical health: ___ Good ___ Fair ___ Poor

Please list all drugs that you are currently taking: ____

Are you taking birth control pills? ___ Yes ___ No Are you pregnant? ___ Yes ___ No ___ Unsure Week #: _______

For orthodontic treatment please complete the following:

What are the main concerns that you would like orthodontics to accomplish? ______________________________

Have you ever been evaluated / had orthodontic treatment before? ___ Yes ___ No

Have there been any injuries to your face, mouth, teeth or chin? ___ Yes ___ No

Have adenoids or tonsils been removed? ___ Yes ___ No Have you been informed of any missing or extra permanent teeth? ___ Yes ___ No

Do you still have your wisdom teeth? ___ Yes ___ No Have you played any musical instruments? ___ Yes ___ No If so, what? _______________

I understand that I am responsible (if 18 years or older) for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's insurance does not cover. **You may print this form out and mail it to us, signed, or you may submit it online and sign it on your first visit.**

____ ____

Patient Signature Date Parent/Guardian Signature (if necessary) Date

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

____

Signature of Patient and/or Parent/Guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

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Signature of Patient and/or Parent/Guardian Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials __________ Date: _________

Doctor's Comments: ____

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