Hiple Family Dentistry
630 3rd Avenue SW Ste 150
Carmel, Indiana 46032

Child New Patient Form

Date:_____

First Name _____ Last Name _____ (Preferred) _____

Date of Birth _____ □ Male □ Female

Child lives with: □ Both Parents □ Mother □ Father

Responsible Party Information

First Name _____ Last Name _____ DOB _____

Address _____ Zip _____

Home # _____ Work # _____ Cell # _____

E-Mail _____

Other Parent's Information

First Name _____ Last Name _____ DOB _____

Address _____ Zip _____

Home # _____ Work # _____ Cell # _____

E-Mail _____

Insurance Information

Primary

Name of insured _____ ID # _____
Subscriber SS# _____ Group # _____
Insurance Company _____ Phone # _____
Employer _____

Appointment Information

Which method would you prefer for having your appointment confirmed? You may select as many as you would like.

□Email □Text to cell □Home or mobile phone call □ All

Dental History

What is the primary reason for today's visit? □Cleaning □Trauma/Dental Emergency
Has your child been to the dentist? □Yes □ No
If yes, Previous/Present Dentist _____ Last Exam Date _____ Last X-ray taken _____
Any previous dental injuries? □ Yes □No
Do you think your child will react well to treatment? □Yes □No

Dental Habits

Does your child currently… (check all that apply)

□Suck Thumb/Finger □Suck/Bite Lips □Bite/Chew Nails □Tongue Thrust
□Use Pacifier □Clench/Grind Teeth □Mouth Breather □Bottle Feed
□Breast Feed □Sippy Cup

Hygiene Routine

(check all that apply)

□Fluoride Toothpaste □Consume Fluoridated Water □Brushing by Child ___/day □Brushing by Parent ___/day
□Fluoride Mouthwash □Dental Floss ___/week

Nutrition

Drinks (check all that apply)
□Water □Juice □Milk □Flavored Milk □Gatorade/Sport Drinks □Soda

Vitamin Supplement □Gummy Vitamin □Crunchy Vitamin □None

Medical History

Child's Primary Care Physician _____ **Phone** _____

History of Hospitalizations/ Operations/ Recent Illnesses _____

Current Medications _____

Are you allergic to or have you reacted adversely to any of the following:

□ Local Anesthetic
□ Sulfa Drugs
□ Metals
□ Aspirin
□ Iodine
□ Penicillin
□ Codeine
□ Sedatives / Sleeping Pills
□ Latex
□ Other _____

Food Allergies _____
Nut Allergies _____

(Check all that apply)

□Anemia/ Blood Disorder
□Abnormal Bleeding/Hemophilia
□Immune Disorder/HIV/AIDS
□Cancer/Tumor/Leukemia
□Heart Murmur/Defect/Surgery
□Epilepsy/Seizures/Convulsions
□Cerebral Palsy
□Kidney Problems
□Congenital Birth Defects
□Cleft Lip/Palate
□Eating Disorder
□Speech Disorder
□Syndromes _____
□Diabetes
□Sickle Cell Trait
□Stomach/GI Disorders
□Tonsillitis
□Tuberculosis
□Asthma
□Liver Disease/Jaundice/Hepatitis
□Sleep Apnea/Snoring
□ADD/ADHD
□Autism Spectrum
□Hearing Problems/Deaf
□Vision Problems
□Other _____

Parental Consent

I, _____ (parent or guardian) do hereby state that in my absence the following individuals may bring my child, _____ (name of child) to any/all office visits at HFD.

1. _____ Relationship to patient _____
2. _____ Relationship to patient _____
3. _____ Relationship to patient _____

CONSENT

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or my medicines I will inform the office at my next appointment without fail.

Our office policy is that patients with insurance pay their deductible as well as the percentage not paid by their policy at the time services are rendered. This signature on file is my authorization for the release of all information necessary to process my claim. I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me for services rendered.

Payment is due in full at the time services are rendered. I understand that I am ultimately financially responsible for all charges incurred including all fees associated with the collection of any delinquent balances on my account.

_____ _____
Signature of Parent/Guardian **date**