NEW PATIENT INFORMATION FORM

Childs Name_____
Last First Middle

Childs Address_____
Nickname_____
Home Phone #_____
Childs Cell #_____
Circle One : Male Female
Date of Birth_____
Referred by:_____ School_____
Pediatrician Name:_____
Pediatrician Phone #_____

Has your child ever had any of the following medical problems? Please circle if yes:

Abnormal Bleeding	Anemia	Cancer
Chicken Pox	Convulsions	Epilepsy
Asthma	Diabetes	Hemophilia
Hepatitis	Hives	Kidney/Liver Problems
Measles	Mononucleosis	Rheumatic/Scarlet Fever
Skin Rash	Tuberculosis	HIV/AIDS- negative

Does your child have a congenital heart defect? Yes No
Does your child have any history of heart murmurs? Yes No
If yes, please list type_____

Has your child been diagnosed with Autism/Special Needs? Yes No
If yes, please explain_____
Is your child allergic to any medications? Yes No
If yes, please list_____

Why did you bring your child to the dentist today?_____

Please indicate if you have other children that have been a patient of Dr. Santiago:
_____

Does/did your child have any of the following habits? Please circle if yes:
Lip Sucking/ Biting Nursing/ Bottle Habits
Nail Biting Thumb/Finger Sucking
Was the child ever breast fed? Yes No Is the child adopted? Yes No

Guardian/Parent #1

Name_____
Last First Middle
Address_____
City Zip
Employer_____ Occupation_____
Insurance Name_____
Insurance ID #_____
Home phone_____ Work phone_____
Cell phone_____
SS#_____-_____-_____ Date of Birth_____/_____/_____

Circle One: Male Female
Marital Status: Single Married Divorced Widowed

Guardian/Parent #2

Name_____
Last First Middle
Address_____
City Zip
Employer_____ Occupation_____
Insurance Name_____
Insurance ID #_____
Home phone_____ Work phone_____
Cell phone_____
SS#_____-_____-_____ Date of Birth_____/_____/_____

Circle One: Male Female
Marital Status: Single Married Divorced Widowed

Guardian/ Parent #1 email address_____
Guardian/ Parent#2 email address_____

Child resides with: Circle One: Guardian/ Parent#1 Guardian/ Parent#2 Both

The guardian/ parent who accompanies the child is responsible for payment at the time of service.
Payment to be made by:
Circle One: Check Cash Credit Card

If you have insurance, we will be happy to file it on your behalf however, the above guarantor is responsible for payment of any non covered procedures or differences in fees.
I understand that the information that I have given is correct to the best of my knowledge that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's account or medical status.
Signature of guardian/ parent_____Date_____