Youth Patient Information Form

BACKGROUND INFORMATION

Date ______________________________

Youth's Name ______________________________ Nickname ______________ ☐ M ☐ F
(First) (MI) (Last)

Home Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Phone (Home) ______________________________ (Cell) ______________________________

Email Address ______________________________ School ______________________________ Grade ______

Birthdate ____/____/____ Social Security # ______________________________

Other family members seen by us? ______________________________

Is the child adopted? ☐ Y ☐ N Is the child in foster care? ☐ Y ☐ N

Whom may we thank for referring you? ______________________________ How did you find out about us? ______________________________

Is there anything you wish to discuss with the dentist in private? ☐ Y ☐ N

PARENT INFORMATION

Marital Status of Parents: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Remarried

MOTHER ☐ Mother ☐ Stepmother ☐ Guardian Birthdate ____/____/____ Social Security # ______________________________

Phone ______________________________
(Home) (Work) (Cell)

Employer ______________________________ Occupation ______________________________ How long? ______

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

FATHER ☐ Father ☐ Stepfather ☐ Guardian Birthdate ____/____/____ Social Security # ______________________________

Phone ______________________________
(Home) (Work) (Cell)

Employer ______________________________ Occupation ______________________________ How long? ______

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

PERSON RESPONSIBLE FOR ACCOUNT ☐ Same as above

Name ______________________________ Relationship ______________________________
(First) (MI) (Last)

Phone ______________________________
(Home) (Work) (Cell)

Social Security # ______________________________ Driver's License # ______________________________

Employer ______________________________

Billing Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Who is responsible for making appointments? ______________________________

Phone ______________________________
(Home) (Work) (Cell)

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE **Please present insurance card to front desk staff**

Dental Coverage? ☐ Y ☐ N

Insured's Name ______________________________ ID # ______________________________

Relationship to Patient ______________________________ Group # (Plan, Local, or Policy #) ______________________________

Insurance Company ______________________________ Insurance Company Phone ______________________________

Insurance Company Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Insured's Employer ______________________________

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

SECONDARY INSURANCE **Please present insurance card to front desk staff**

Dental Coverage? ☐ Y ☐ N

Insured's Name ______________________________ ID # ______________________________

Relationship to Patient ______________________________ Group # (Plan, Local, or Policy #) ______________________________

Insurance Company ______________________________ Insurance Company Phone ______________________________

Insurance Company Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Insured's Employer ______________________________

Employer's Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

You are responsible for paying your account balance and for informing us of any changes in your child's insurance. Thank you.

DENTAL HISTORY

Reason for seeing the dentist today: ______________________________

____

Is the youth currently in pain? ☐ Y ☐ N
Is the youth's water fluoridated? ☐ Y ☐ N
Is the youth taking fluoridated supplements? ☐ Y ☐ N
Has the youth ever experienced an injury to the mouth, teeth, or jaw? ☐ Y ☐ N
Does the youth brush daily? ☐ Y ☐ N
Does the youth floss daily? ☐ Y ☐ N
Does the youth now (or has the youth ever) had pain or tenderness in the jaw joint (TMJ/TMD)? ☐ Y ☐ N

Previous Dentist, if applicable ______________ Date of Last Visit ______________

Why did you leave your previous dentist? ______________________________

What have you liked most and/or least about any dentist you have ever seen? ______________________________

MEDICAL HISTORY

Current Physician ______________________________

Address ______________________________
(Street/P.O. Box) (City) (State) (ZIP)

Phone ______________ Date of Last Visit ______________

Current physical health is: ☐ Good ☐ Fair ☐ Poor

Is the youth currently under the care of a physician? ☐ Y ☐ N Please explain: ______________

____

Is the youth taking any prescriptions, over-the-counter medications, vitamins, or minerals? ☐ Y ☐ N

If so, please indicate what the youth is taking: ______________________________

____

Please indicate any allergies: ______________________________

____

Please circle any of the following medical issues your youth is currently experiencing *or* has previously experienced:

Abnormal Bleeding	Asthma	Diabetes	Hepatitis	Liver Problems	Scarlet Fever
ADD/ADHD	Cancer	Epilepsy	Herpes	Low Blood Pressure	Skin Rash
AIDS	Chicken Pox	Handicaps / Disabilities	High Blood Pressure	Lupus	Tuberculosis (TB)
Anemia	Colitis	Hearing Impairment	HIV+/AIDS	Measles	Ulcers
Any Hospital Stays	Congenital Heart Defect	Heart Murmur	Hives	Mononucleosis	Venereal Disease
Any Operations	Convulsions	Hemophilia	Kidney Problems	Rheumatic Fever	

Please indicate any other medical condition(s) not indicated above: ______________________________

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Please circle any of the following the youth is experiencing or has experienced:

Lip Sucking / Biting	Nail Biting	Chewing on Objects
Mouth Breathing	Clenching / Grinding Teeth	Uses a Pacifier
Thumb / Finger Sucking	Tongue / Cheek Biting	Speech Development Issues
Tongue Thrust	Other (please indicate) ______________	

AUTHORIZATION

I affirm 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 Morningside Dental of any changes in my child's medical or insuarnce status. I authorize the staff of Morningside Dental to perform the necessary dental services he/she may need. My method of payment will be______________ .

____
Signature Date

Payment is due at time of service. The parent or guardian who accompanies the youth is responsible for payment at time of service unless prior arrangements have been approved by Morningside Dental.

Morningside Dental is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information with the parent or guardian named herein. Initials ________ Date ______________

Doctor's Comments: ______________________________

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