Youth Patient Information Form

Date_____

Please print

BACKGROUND INFORMATION

Name_____ Nickname_____ ___M ___F

Date of Birth_____ Social Security #_____

Home Address_____ City/State/ZIP_____

Home Phone_____ Cell Phone_____

Email Address_____ School_____ Grade_____

Family members who are patients?_____ Referred By_____

How did you learn about us? __Friend/Family __Newspaper __Yellow Pages __Walk-In/Drive By __Other_____

Parents' Marital Status: __Single __Married __Widowed __Divorced Person scheduling appointments?_____

PARENT/GUARDIAN 1_____ Date of Birth_____

Email Address_____ Social Security #_____

Home Address_____ City/State/ZIP_____

Home Phone_____ Cell Phone_____

Employer/Occupation_____ Employer Phone_____

PARENT/GUARDIAN 2_____ Date of Birth_____

Email Address_____ Social Security #_____

Home Address_____ City/State/ZIP_____

Home Phone_____ Cell Phone_____

Employer/Occupation_____ Employer Phone_____

PERSON RESPONSIBLE FOR ACCOUNT ___*Same as above*

Name_____ Social Security #_____ Relationship_____

Billing Address_____ City/State/ZIP_____

Home Phone_____ Cell Phone_____

Employer_____ Employer Phone_____

DENTAL INSURANCE INFORMATION

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

Insured's Name_____

Insured's Social Security #_____ Insured's Date of Birth_____

Relationship to Patient_____ Group # (Plan, Local, or Policy #)_____

Insurance Company_____ Insurance Company Phone_____

Insurance Company Address_____ City/State/ZIP_____

Insured's Employer_____ Employer's Phone_____

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

Insured's Name_____

Insured's Social Security #_____ Insured's Date of Birth_____

Relationship to Patient_____ Group # (Plan, Local, or Policy #)_____

Insurance Company_____ Insurance Company Phone_____

Insurance Company Address_____ City/State/ZIP_____

Insured's Employer_____ Employer's Phone_____

DENTAL HISTORY

Reason for seeing Dr. Kiple today?_____ Is the child in pain? ___Yes ___No

Is youth's water fluoridated? ___Yes ___No Does youth take fluoridated supplements? ___Yes ___No

Does child brush daily? ___Yes ___No Does child floss daily? ___Yes ___No

Is the youth having (or has the youth had) pain or tenderness in the jaw joint? ___Yes ___No

Has the child ever experienced an injury to the mouth, teeth, or jaws? ___Yes ___No

Bristles on toothbrush? ___Hard ___Medium ___Soft How often is the child's toothbrush replaced?_____

Previous dentist, if applicable?_____ Last visit?_____ Why did you leave?_____

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

MEDICAL HISTORY

Family Doctor_____ Phone_____

Date of Last Visit_____ Current Health ___Good ___Fair ___Poor

Currently under a physician's care? ___Yes ___No Explain:_____

MEDICATIONS Is youth taking any medications (prescription or over-the-counter), vitamins, or minerals?

___Yes ___No If yes, please indicate all:_____

ALLERGIES Please indicate any allergies:_____

MEDICAL CONDITIONS Please circle any conditions the child is experiencing or has experienced:

Abnormal Bleeding	Congenital Heart Defect	Hemophilia	Kidney Problems	Rheumatic Fever
ADD/ADHD	Convulsions	Hepatitis	Liver Problems	Scarlet Fever
Anemia	Diabetes	Herpes/Fever Blisters	Low Blood Pressure	Skin Rash
Asthma	Disability:_____	High Blood Pressure	Lupus	Tuberculosis (TB)
Cancer	Epilepsy	HIV+/AIDS	Measles	Ulcers
Chicken Pox	Fainting Spells	Hives	Mononucleosis	No Known Conditions
Colitis	Heart Murmur	Hospital Stay:_____	Operation:_____	Other:_____

Please indicate any medical condition(s) not noted above:_____

ORAL HEALTH Please circle any that are relevant to the child:

Chewing on Objects	Lip Sucking / Biting	Pacifier Use	Thumb / Finger Sucking	No Known Conditions
Clenching Teeth	Mouth Breathing	Speech Development Issues	Tongue / Cheek Biting	Other:_____
Grinding Teeth	Nail Biting		Tongue Thrust	

Please share any oral health concerns you wish to discuss with Dr. Kiple:_____

AUTHORIZATION

Please initial each statement where noted and sign as indicated. Thank you.

___I understand it is my responsibility to inform Morningside Dental of any changes in my child's medical or insurance status.

___I understand that 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.

___I certify that the information on this form is correct to the best of my knowledge and will be held in the strictest confidence.

___I authorize the staff of Morningside Dental to perform the necessary dental services he/she may need. My method of payment will be as follows: __Cash __Check __Credit/Debit __CareCredit

_____

Signature Date

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