# DRS. NEWBERN AND NEWBERN

## PATIENT INFORMATION

Date _____ Sex: ☐ Male ☐ Female

Patient's Name _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ Cell Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

## RESPONSIBLE PARTY INFORMATION

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) Marital Status _____

Residence _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Mailing address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

How long at this address _____ Home Phone _____ Cell Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (LAST) _____ (FIRST) _____ (MIDDLE) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

## INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No _____

Insurance Co. Address _____

Do you have dual coverage? ☐ Yes ☐ No If yes:

Insured's name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

## EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Payment is due when services are rendered. As a courtesy to our patients we will submit claims to your insurance company. You are expected to pay your portion (deductible and percentage) at the time of service. Any services not paid by the insurance company within 45 days from the date of service will become the patient's responsibility. Service charges will be added to any remaining balance over 60 days.

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

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## MEDICAL HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Any problems at that time? _____

| | | YES | NO |
|---|---|---|---|
| 1. | Is your child presently taking any medications? | ❑ | ❑ |
| | If so, what _____ | | |
| 2. | Has your child ever been hospitalized? | ❑ | ❑ |
| | If so, for what reason _____ | | |
| | _____ | | |
| 3. | Has your child ever had an operation? | ❑ | ❑ |
| 4. | Is there any known allergy to drug(s)? | ❑ | ❑ |
| | If so, please name _____ | | |
| 5. | Is there any known food or other allergy? | ❑ | ❑ |
| | If so, please name _____ | | |
| 6. | Are immunizations up to date? | ❑ | ❑ |
| 7. | Is there any known allergy to metal? | ❑ | ❑ |
| | If so, please name _____ | | |

Additional Information: _____

Has your child had any history of any of the following?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Anemia or blood disorder | ❑ | ❑ | Heart defect or murmur | ❑ | ❑ |
| Asthma | ❑ | ❑ | Hepatitis/liver disorder | ❑ | ❑ |
| Birth defects | ❑ | ❑ | Kidney disease | ❑ | ❑ |
| Bleeding disorder | ❑ | ❑ | Lung disease | ❑ | ❑ |
| Breathing difficulty | ❑ | ❑ | Measles | ❑ | ❑ |
| Broken bones | ❑ | ❑ | Mental retardation | ❑ | ❑ |
| Chicken pox | ❑ | ❑ | Mononucleosis | ❑ | ❑ |
| Convulsions/Seizures | ❑ | ❑ | Mumps | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Neurological disorder | ❑ | ❑ |
| Emotional Problems | ❑ | ❑ | Rheumatic fever | ❑ | ❑ |
| Epilepsy | ❑ | ❑ | Thyroid disorder | ❑ | ❑ |
| Fainting or dizziness | ❑ | ❑ | Vision problems | ❑ | ❑ |
| Hearing problems | ❑ | ❑ | Other _____ | | |

**MEDICAL HISTORY UPDATE**

1. _____
2. _____
3. _____

## DENTAL HISTORY

1. Date of last visit to dentist _____ _____
2. For what service? _____

_____

| | | YES | NO |
|---|---|---|---|
| 3. | Has child complained about dental problems? | ❑ | ❑ |
| | If so, please comment _____ | | |
| 4. | Any unhappy dental experiences? | ❑ | ❑ |
| | If so, please comment _____ | | |
| | _____ | | |
| 5. | Any oral habits: | | |
| | Thumb sucking | ❑ | ❑ |
| | Finger sucking | ❑ | ❑ |
| | Mouth breathing | ❑ | ❑ |
| | Lip sucking | ❑ | ❑ |
| | Grinding of teeth | ❑ | ❑ |

| | | YES | NO |
|---|---|---|---|
| 6. | Did your child ever sleep with a bottle? | ❑ | ❑ |
| | If so, what did the bottle contain? _____ | | |
| | At what age was the bottle stopped? _____ | | |
| 7. | Any speech difficulties? | ❑ | ❑ |
| | If so, please comment _____ | | |
| 8. | Does your child brush his/her own teeth? | ❑ | ❑ |
| | If so, when _____ | | |
| | If not, by whom _____ | | |
| 9. | Is water supply fluoridated? | ❑ | ❑ |
| | If not, any fluoride medication used? | ❑ | ❑ |
| 10. | Has your child ever had any injuries to | | |
| | mouth / teeth / head? | ❑ | ❑ |
| | If so, please comment _____ | | |
| | _____ | | |

It is customary to take care of fee at the time service is rendered unless other financial arrangements have been made. To assist you with this we accept most credit cards.

Dental insurance is welcome; however, it should be understood that you will be responsible for any portion not paid by insurance.

Parent's Signature _____

Date _____

**Thank you,**

**Newbern Family Dental Practice**

PPI-23167

Newbern Family Dental Practice
800 Northwood Park Drive
Valdosta, Georgia 31602
229/242-6202

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients, as well as the practice.

If you find that you must change your appointment, we require a minimum of 48-hours notice so that we may accommodate another patient. A charge will be applied for broken and missed appointments without a 48-hour advance notification. Please sign this letter to signify that you have read and understand our office policy concerning broken appointments.

Thank you for your cooperation in this matter.

Signature_____ Date _____