New Patient Under 18 Form | David Lester, DDS

Child's Name:

_____

Last **First** **Middle**

Date of Birth: _____

Residence Address: _____

City: _____ **State:** _____ **Zip:** _____

Parent or Guardian: _____

Best Phone Number to Reach You Regarding This Patient: _____

Parent/Guardian Email: _____

Emergency Contact (Name & Phone number): _____

How would you prefer we contact you regarding this patient?:

CALL TEXT EMAIL

IF APPLICABLE:

Dental Insurance Company: _____

Subscriber Name: _____ **Date of Birth:** _____

Insurance ID Number: _____ **Group Number:** _____

Employer: _____

Business Address: _____

City: _____ **State:** _____ **Zip:** _____

Business Phone: _____

If you have additional insurance, please complete below:

Dental Insurance Company: _____

Subscriber Name: _____ **Date of Birth:** _____

Insurance ID Number: _____ **Group Number:** _____

Employer: _____

How did you hear about us? _____

Date of last Dental visit: _____

Previous Dentist: _____

Has the patient had any trouble associated with previous dental treatment? Yes / No

If yes, please explain: _____

DISCLOSURE

David Lester, DDS has my authorization to disclose this patient's Medical and Insurance information to the following person(s):

Name(s): _____

Phone: (_____) _____ **E-Mail:** _____

Patients under the age of 18

PLEASE COMPLETE THIS INFORMATION FOR OUR RECORDS

MEDICAL INFORMATION

Physician's Name: _____

Physician's Phone Number: _____

In the patient in good health?: YES / NO

Date of last physical exam? _____

Has the patient been admitted to the hospital in the last three years? YES / NO

If yes, for what reason? _____

Is the patient currently taking any medication? YES / NO

If yes, please list any medications the patient is currently taking: _____

_____

_____

Please circle any medications to which the patient are allergic:

PENICILLIN CODEINE ASPIRIN LIDOCAINE CARBOCAINE

OTHER: _____

Name and Location of Pharmacy for Prescriptions: _____

Has the patient ever had any excessive bleeding that needed special treatment? YES / NO

If yes, please explain: _____

Are you currently taking blood thinners: YES / NO

Please circle ANY the patient *may* have or *has* had:

Anemia	Low Blood Pressure	Radiation Therapy
Muscle Problems	High Blood Pressure	Hepatitis
Allergies	HIV Positive	Asthma
Epilepsy	Arthritis	Fainting Spells
Tumor	Hypoglycemia	Skin Problems
Kidney Trouble	Sinus Problems	Other:
Heart Troubles	Diabetes	_____

CONSENT FOR TREATMENT:

I understand that it is the responsibility of this patient's parent/legal guardian to inform Dr. Lester of any changes in the patient's health. I, the undersigned and legally responsible party, authorize and request the performance of dental services for this patient and, further the performance of any operation rendered by the dentist and his staff. I also authorize the administration of such anesthetics or analgesics, local or inhalation, which the doctor may deem advisable. Furthermore, I will be responsible for any financial obligations incurred for dental treatment upon the above name patient. I understand that the charges are my personal responsibility regardless of insurance benefits.

Signature: _____ **Date:** _____