West Hills Dental welcomes your family to our practice!

We are sending you new patient forms to save you the time of filling them out when you arrive at your child's appointment. Enclosed you will find a patient health history form and a getting to know your child form. Kindly fill them out and return them to our office prior to your child's appointment (West Hills Dental, 2615 Elk Drive, Suite #2, Minot ND 58701). It is very important that you fill in the all information, including all social security numbers and insurance information, if applicable. With this information we are able to verify your dental coverage and charge accordingly the day of service. If your child has been seen with a different provider, please contact that office to have any current x-rays sent to us (westhillsdental@srt.com).

Payment is required at the time of service. We accept cash, checks, and VISA/Master Card/American Express. Some insurance companies cover the charges for the first visit, so please be sure to bring your dental insurance card with you.

If you are unable to keep your child's appointment, kindly give our office a 24-hour cancellation notice. Should you fail your child's appointment, we may not be able to reschedule your child. If you have any questions, you may contact us at 701.837.1050.

We look forward to seeing your child for their reserved appointment. We have enclosed an appointment card. Please arrive 15 minutes early so we may ensure we have all of the appropriate new patient paperwork entered and the hygienist can start with you in a timely matter.

Sincerely,

Office Coordinators & Dr.Stephanie Ness

Child Patient Registration

ID: _____ Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist: _____

Employer ID: Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

EMERGENCY CONTACT: _____

EMERGENCY #: _____

PHYCISIANS NAME: _____

PHYCISIANS #: _____

MOMS CELL #: _____

DADS CELL #: _____

GUARDIANS NAME: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: Rem. Deduct: _____

West Hills Dental

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

Child's Name: _____ **Age:** _____

1. Has your child seen the dentist before?
- ○ A. Yes
- ○ B. No

2. Has your child ever had any cavities or fillings?
- ○ A. Yes
- ○ B. No

3. Has any of the child's siblings ever had a cavity or filling?
- ○ A. No
- ○ B. Yes

4. Has your child ever seen an Orthodontist?
- ○ A. Yes
- ○ B. No

5. Does your child suck their thumb, fingers, or use a pacifier?
- ○ A. Yes
- ○ B. No

6. How often does your child brush his/her teeth?
- ○ A. At least twice a day
- ○ B. Once a day
- ○ C. Never or less than once a day

7. Does your child use fluoride toothpaste?
- ○ A. Uses fluoride toothpaste or training toothpaste
- ○ B. Does not use fluoride toothpaste

8. How often does your child floss?
- ○ A. Daily
- ○ B. Once a week, not daily
- ○ C. Never

9. How often does your child eat snacks throughout the day?
- ○ A. Never/Rarely
- ○ B. Occasionally
- ○ C. Several or Constant snacking

10. Which one best describes when your child eats sweets?
- ○ A. Never/Rarely
- ○ B. At meal time
- ○ C. With or as a snack

11. How often does your child drink juice or soda?
- ○ A. Never/Rarely
- ○ B. A few times per week or on weekends
- ○ C. Daily, consumed fast
- ○ D. Daily, consumed slowly

12. Does your child chew sugar free gum?
- ○ A. Yes or doesn't chew gum
- ○ B. Chews gum with sugar