Patient Information Sheet

(18 & older)

Date _____

Patient's Last, First Name _____ Nickname_____ DOB_____ Age_____

Female or Male Was patient adopted? Yes or No List family siblings_____

Patient's Address _____ City _____ Zip _____

Patient's Cell Phone: _____-_____ Email_____

Insurance/Employer Information (Whether you have insurance or not)

Insurance Carrier_____ Subscriber Name_____

Employer_____Employer Phone_____-_____

Dental Insurance/Address_____Phone_____-_____

Group # _____ Member ID#_____

Person financially responsible for the account?_____

Dental Information

What is the purpose of this dental visit? _____

X-rays from another office? Please email to **office@thefunkidsdentist.com** Previous dentist_____

How did you hear about our office? Google Instagram Facebook Tik Tok School Presentation Mom's Group

Friend (please name)_____ Doctor (please name) _____ Other_____

Patient Medical Information Pediatrician/Physician_____ Phone_____-_____

Any history of the following:

_____ ADD/ADHD
_____Anemia
_____Anxiety/Depression
_____Asthma
_____Austism
_____Birth Defect-Premature/Syndrome
_____Bleeding Disorder
_____Cancer
_____Cerebal Palsy
_____Chronic Ear Infections
_____Cleft Lip/Palate

_____Cystic Fibrosis
_____Developmentally Delayed
Age Level_____
_____Diabetes
_____Down Syndrome
_____Eating Disorder
_____Epilepsy/Seizures
_____Gastroesophageal/Acid Reflux
_____G-Tube Feeding
_____GI Problem
_____Hearing Loss/Deafness
_____Vision Loss/Impairment

_____Heart Defect/Disease
_____HIV+/AIDS
_____Hydrocephaly/shunt
_____Learning Disability
_____Liver/Kidney Problems
_____Orthopedic Pins/Rods/Plates
_____Sickle Cell Disease/Trait
_____Skin Problems
_____Sleep Apnea/Snoring/Gagging
_____Speech Delay/Impairment
_____Tobacco Use
_____NONE

Allergies (drug, environmental, food) _____

Hospitalizations/Surgeries_____Medications_____

Please provide details of anything noted above_____

Patient Signature _____ **Date**_____