THE DENTAL CARE CENTER
HIGGINS, MANI & WATSON, DDS, PA
Kids
General Family Dentistry

3001 B Raleigh Road Parkway West,
Wilson NC 27896

Phone: 252-293-4469
FAX: 252-293-4479

New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____

Child's Home #: (____)_____

SSN: _____

Child's Home Address: _____

_____
City State Zip

2 MOTHER'S INFORMATION

Name: _____

Mother Stepmother Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

3 FATHER'S INFORMATION

Name: _____

Father Stepfather Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

4 HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ YES ☐ NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

Email Address: _____

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

9 DENTAL HISTORY

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

_____

_____

Why did you bring your child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing / Bottle Habits
Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: _____

_____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his/her teeth daily? YES NO

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Hemophilia/Blood Disorders
Y N Reflux/GI Problems

Please discuss any serious medical conditions the child has had:

_____

_____

Please list all the drugs the child is currently taking: _____

_____

Please list all drugs the child is allergic to: _____

_____

Child's Physician: _____

Phone #: (____) _____

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:
GOOD FAIR POOR

11

I request and authorize Dental Care Center to examine, clean and provide necessary dental treatment for me/the patient. I further request and authorize the taking of dental x-rays/ photographs as may be considered necessary for diagnostic or educational purposes. I understand that this office only uses composite (tooth colored) filling material and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

PHOTOGRAPHIC RELEASE AND CONSENT

I hereby consent and authorize The Dental Care Center to take photographs, sides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used a s record of my care, ,and my be used with our without my given name or with a fictitious name for educational purposes in lectures,, demonstrations, advertising, professional publications (dental magazines and journals) and any other lawful purpose.

I release and forever discharge The Dental Care Center and its designated representatives from any claim, demands, or liability on account of such use or for the quality of the reproduction of the image.

Signature of Parent or Guardian_____ Date_____ Relationship to Patient_____