Richard M. Quinn DDS
Julie Quinn Nies DDS MSD

New Patient Questionnaire & Consent

Today's Date: _____

Tell Us About Your Child

Child's Name: Last_____First_____MI_____Nickname_____
M or **F** Age:_____ Birthday: _____Place of Birth:_____
School: _____ Grade: _____
Names and Ages of Siblings: _____
Who may we thank for referring you to our office?
_____

General Information

Residence Address: _____ Phone #_____
City_____ State _____Zip Code _____
MOTHER'S INFORMATION:
Name: _____ Birth Date _____SSN _____
Employer: _____Work # _____ Cell # _____
FATHER'S INFORMATION:
Name: _____ Birth Date _____SSN _____
Employer: _____Work # _____ Cell # _____

Who is accompanying the child today? _____ Relationship
_____

Do you have legal custody of this child? **YES** or **NO**
If yes, please provide appropriate documentation to the front desk. If no, please provide a letter from the guardian giving permission for you to accompany the child.

MEDICAL HISTORY

Since your child's overall general health may influence his or her dental treatment, please answer the following questions concerning your child's medical status:

Please describe your child's current physical health: ____Good ____ Fair ____ Poor
Is your child: _____ Advanced ____ Progressing Normally ____ A Slow Learner ___ Hyperactive

Does (or has) your child have (or ever had) any of the following conditions?

Y N Complications during pregnancy	Y N Heart Disease/Murmur	Y N Diabetes
Y N Prematurity at birth	Y N Heart Surgery	Y N Asthma, Pneumonia
Y N Congenital Birth Defects	Y N Rheumatic/Scarlet Fever	Y N Tuberculosis
Y N Psychological Counseling	Y N High Blood Pressure	Y N Speech Problems
Y N Disabilities/Special Needs	Y N Hemophelia/Blood Disorders	Y N Sleep Problems
Y N Autism Spectrum Disorder	Y N Abnormal Bleeding	Y N Tonsil/Adenoid Problems
Y N ADD/ADHD	Y N Anemia or Sickle Cell Disease	Y N Mouth Breather
Y N Cerebral Palsy	Y N Liver/Kidney Conditions	Y N Sinus Problems
Y N Convulsions/Seizures	Y N Hepatitis	Y N Cleft Lip/Palate
Y N Trauma to Head	Y N HIV + / AIDS	
Y N Sensory Disorders	Y N Pregnancy	

Y N Allergies to Any Drugs	Y N Allergy to Latex Products
Y N Any Operations	Y N Any Hospital Stays

Please discuss any serious medical conditions this child has had: _____
_____
_____
Please list all current medications: _____
_____
Please list all allergies (drugs, food, dye, seasonal, other):_____
_____

Child's Physician: _____ Date of last Physical Exam: _____
Address: _____ Phone Number: _____
Up to Date on Vaccinations? Yes No

DENTAL HISTORY

Is this your child's first visit to the dentist? Yes No If No, when was the last visit? _____
Previous Dentist _____ Family Dentist _____
Reason for Today's Visit: _____
Has your child had a toothache recently? Yes No
If Yes, please explain: _____
Has your child ever injured their mouth, teeth or jaw? Yes No
If Yes, please explain: _____
Does your child have a history of any TMJ clicking, popping or pain? Yes No
If Yes, please explain: _____
Does (or has) your child have (or had) a sucking habit beyond one year of age? Yes No
If Yes, check all that apply: ____ Thumb ____ Finger ____Pacifier Other: _____
Does (or has) your child have (or had) any other oral habits? Yes No
If Yes, check all that apply: ____ Nail biting ____ Teeth grinding Other: _____

DENTAL HEALTH

Is the child's water fluoridated? Yes No Is the child taking fluoride supplements? Yes No
Does the child brush his/her teeth daily? Yes No Does the child floss his/her teeth daily? Yes No
Is tooth brushing supervised? Yes No If Yes, by whom? _____

Was your child breast fed? Yes No Until what age? _____
Was your child bottle fed? Yes No Until what age? _____
Does your child take a bottle/cup to bed? Yes No If Yes, what is in the bottle/cup? _____

METHOD OF PAYMENT : Cash ____ Credit Card ____ Insurance _____ Medicaid _____ Other _____

CONSENT

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

YOUR CHILD IS A MINOR, THEREFORE IT IS NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR LEGAL GUARDIAN BEFORE ANY NECESSARY DENTAL SERVICES CAN BE PERFORMED. **I GRANT RICHARD M. QUINN DDS, AND JULIE Q. NIES DDS** PERMISSION TO PROVIDE MY CHILD'S DENTAL EXAM AND TREATMENT, AND I WILL BE RESPONSIBLE FOR THE COST OF THE DENTAL CARE. I UNDERSTAND THAT I AM COMPLETELY FINANCIALLY RESPONSIBLE FOR ALL TREATMENT INCURRED BY THE ABOVE-NAMED PATIENT IN THIS OFFICE, INCLUDING ANY AMOUNTS NOT PAID BY MY INSURANCE COMPANY (IF ANY) WITHIN 30 DAYS OF TREATMENT. I UNDERSTAND INTEREST WILL BE CHARGED ON ANY UNPAID AMOUNTS MORE THAN 60 DAYS PAST DUE AT AN ANNUAL PERCENTAGE RANGE OF 18%. I PROMISE TO PAY ANY LEGAL INTEREST ON THE BALANCE DUE, TOGETHER WITH ANY COLLECTION COSTS OR ATTORNEY FEES INCURRED TO AFFECT COLLECTION OF THIS ACCOUNT SHOULD MY ACCOUNT BE TURNED OVER TO A THIRD PARTY.

SIGNED_____
Parent or Guardian Date