Dr. Jacqueline Wingate
growing beautiful smiles

Board Certified Pediatric Dentist
325 West Street, Suite 101, Canandaigua, NY 14424
Phone: 585-394-4058 Fax: 585-394-6108

PATIENT INFORMATION

We welcome your child into our practice and we will try to make his/her dental experiences pleasant.
Please complete this form so we may better understand and care for your child.

PATIENT NAME:_____Nickname/Preferred Name:_____
Last First MI
Male ☐ Female ☐ DOB: ____/____/_____ Age: _____ Referred by: _____

Please list the primary contact for the patient, the parent we should call first to confirm appointments:

PARENT # 1 NAME: _____ Relationship to patient: _____
Parent's DOB: ____/____/_____ Parent's SSN (for insurance and verification) _____-_____-_____
Mailing address: _____ Apt/Lot #_____ City: _____
State: _____ Zip Code: _____ Home Phone #: (____)_____
Cell Phone #: (____)_____ Text messaging enabled? Yes ☐ No ☐ Marital Status: Sing.☐ Mar.☐ Div.☐ Wid.☐
Employer: _____ Work Phone #: (____)_____ Ext. _____
Parent's e-mail address (for patient portal access):_____@_____

Please list the patient's other parent or guardian:

PARENT # 2 NAME: _____ Relationship to patient: _____
Parent's DOB: ____/____/_____ Parent's SSN (for insurance and verification) _____-_____-_____
Mailing address: _____ Apt/Lot #_____ City: _____
State: _____ Zip Code: _____ Home Phone #: (____)_____
Cell Phone #: (____)_____ Text messaging enabled? Yes ☐ No ☐ Marital Status: Sing.☐ Mar.☐ Div.☐ Wid.☐
Employer: _____ Work Phone #: (____)_____Ext. _____
Parent's e-mail address (for patient portal access):_____@_____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE
Name of insured/subscriber: _____ DOB: ____/____/_____
Employer: _____
Insurance carrier: _____ Phone #: _____
Ins. Co. Billing Address: _____
Subscriber ID #: _____ Group #_____

SECONDARY DENTAL INSURANCE
Name of insured/subscriber: _____ DOB: ____/____/_____
Employer: _____
Insurance carrier: _____ Phone #: _____
Ins. Co. Billing Address: _____
Subscriber ID #: _____ Group #_____

Primary Care Doctor:_____ **Last Visit:** _____ **Phone:**_____

Has your child had or do they currently have any of the following? Please check those that apply:

- ☐ ADD
- ☐ ADHD
- ☐ AIDS
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral Disorder
  - ○ _____
- ☐ Blood Disease
  - ○ _____
- ☐ Cancer
  - ○ _____
- ☐ Central line/Medi-Port
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Developmental Delays
- ☐ Diabetes
  - ○ _____
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Head Injuries
- ☐ Hearing impairment
- ☐ Hearing loss
- ☐ Heart arrhythmia
- ☐ Heart disease
  - ○ _____
- ☐ Heart murmur
  - ○ Pre-Med? Y ☐ N ☐
  - ○ Cardiologist? _____
- ☐ Hemophilia
- ☐ Hepatitis
  - ○ _____
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental disorders
  - ○ _____
- ☐ Radiation treatment
- ☐ Respiratory problems
  - ○ _____
- ☐ Rheumatic fever
- ☐ Seizures/epilepsy
- ☐ Sinus problems
  - ○ _____
- ☐ Stomach problems
  - ○ _____
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

Does your child have <u>ANY</u> other conditions that we should be aware of? Yes ☐ No ☐ **If yes, please list below:**

_____

Is your child up to date on immunizations? Yes ☐ No ☐

Does your child take <u>ANY</u> medications of <u>ANY</u> kind, even only "as needed"? Yes ☐ No ☐ **If yes, please list below:**

_____

Does your child have <u>ANY</u> allergies of <u>ANY</u> kind? Yes ☐ No ☐ **If yes, please list below:**

_____

Has your child had any past surgeries or been admitted to the hospital? Yes ☐ No ☐ **If yes, please explain with dates:**

_____

If your child is new to our practice:

When was their last dental visit? _____ Dentist? _____ X-rays taken? Yes ☐ No ☐

Has your child had an unfavorable dental experience? Yes ☐ No ☐ **If yes, please explain:**

_____

Does your child have a current or past history of thumb or finger sucking? Yes ☐ No ☐
Does your child have a current or past history of pacifier use? Yes ☐ No ☐
Was your child breast fed? Yes ☐ No ☐ Age discontinued____
Was your child bottle fed? Yes ☐ No ☐ Age discontinued ____
What is your water source? Public system ☐ Private well ☐ Bottled water ☐

To the best of my knowledge, all of the information provided is true and correct. It is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Jacqueline Wingate and the dental staff to perform the necessary dental services my child may need. I agree to be responsible for all charges for dental services, consultations, and materials at the time of the visit. I understand all insurance claims will be submitted on my behalf and the insurance reimbursement will be paid directly to be as determined by my individual policy. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with all insurance claims.

_____ _____

Parent/Guardian Signature **Date**