



Sandra Armstrong, D.D.S.

PEDIATRIC AND ADOLESCENT DENTISTRY
2915 E. Southlake Blvd. Suite 200
Southlake, TX 76092
817-488-3533/Metro 817-329-1422
Fax 817-421-9221

We welcome your child into our practice and we will try to make his/her dental experiences very pleasant. Please complete this form thoroughly. This information is of great value in helping us to better understand and care for your child.

Patient's Name _____ Nickname _____ Age _____

Sex _____ Date of Birth _____ SS# _____ Weight _____

Patient's Address _____
Street City State ZIP

Home Phone _____ Cell Phone (M) _____ (D) _____

Father's Name _____ DOB _____ SS# _____

E-Mail Address _____ Texas DL# _____

His Address _____ Phone _____
Street City State ZIP

Where Employed _____ Occupation _____

Business Address _____ Work Phone _____

Mother's Name _____ DOB _____ SS# _____

E-Mail Address _____ Texas DL# _____

Her Address _____ Phone _____
Street City State ZIP

Where Employed _____ Occupation _____

Business Address _____ Work Phone _____

Primary Dental Insurance Co. _____ Covered by: Mother Father

Insurance Address _____ Phone # _____ Policy # _____

In case of Emergency – Name of nearest relative or friend _____ Phone # _____

With whom does the patient live _____

Other Family Members who see Dr. Armstrong _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office? Doctor Parent Patient Other _____

_____ Street Address of RFD City State ZIP

What is the reason for your visit today? _____

Dental and Family History

Has your child been seen by any other dentist? _____ **Yes** _____ **No** _____

Date and Location of last dental care? _____

Has your child had an unfavorable dental experience? _____

Does your child have a toothache? _____

How many days/weeks? _____ How Frequent? _____

Does your child have past/current history of: Thumb Sucking? _____ Finger Sucking? _____ Pacifier? _____

Has your child ever had a space maintainer, braces or any dental tooth movement? _____

Was your child: Breast-fed? _____ Bottle-Fed? _____ Age Discontinued? _____

Is there family history of bad bites, missing teeth or extra teeth? _____

What is your water source? Public System Private - Well

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