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General Dentistry

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DENTISTRY

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Patient Registration Form

Note: Payment is expected at the time of service

Today's Date: _____

Please tell us about your child

Your Child's Name: _____

Nickname: _____

Child's Birthday:_____Age:_____
School:_____Grade:_____

Child's Address:_____

City:_____State:_____Zip:_____

Child's Phone Number: _____

Siblings that we treat: _____

Who may we thank for referring you to our office?

_____

Mother's Information

Name: _____

Mother-Stepmother-Grandmother-Guardian

Birthdate:_____SS#:_____

Employer: _____

Address:_____

City:_____State:_____Zip:_____

Home#_____Work#:_____

Cell#:_____

DL# _____

Email: _____

Father's Information

Name: _____

Father StepFather GrandFather Guardian

Birthdate:_____SS#:_____

Employer: _____

Address:_____

City:_____State:_____Zip:_____

Home#_____Work#:_____

Cell#:_____

DL# _____

Email: _____

Responsible Party:

Name: _____

Relationship to Patient: _____

Address:_____

City:_____State:_____Zip:_____

Primary Insurance Name:

_____

Phone #:_____

Policy #:_____

Group# _____

Policy Holder Name: _____

Secondary Insurance Name:

_____

Phone #:_____

Policy #:_____

Group# _____

Policy Holder Name: _____

Does your child have Medicaid? YES or NO

Who is Accompanying the Child Today?

Name:_____

Do you have legal custody to this child?

_____

Emergency contact other than yourself?

_____

Phone # _____

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 it is my responsibility to inform this office of any changes in my child's medical status.

_____

Signature of Parent or Guardian

_____

Relationship to Patient

Medical History

Have you ever had any of the following?

Y N Abdominal Bleeding
Y N Anemia
Y N Asthma
Y N Cancer/Tumor/Leukemia
Y N Cerebral Palsy
Y N Cleft Lip Palate
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Emotional Problems
Y N Hearing Impairment
Y N Heart Disease Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis/Liver Problems
Y N HIV/AIDS
Y N Hyperactive Disorder
Y N Kidney Disease
Y N Latex/Ribber Allergy
Y N Liver Disease
Y N Malignant Hyperthermia
Y N Pregnancy
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Anemia/Trait
Y N Speech/Hearing Problems
Y N Thyroid Disorders
Y N Transplants
Y N Tuberculosis
Y N Other

1. Does your child have any drug allergies? _____
2. Please discuss any serious medical conditions the child has had? _____
_____
3. Please list all the medications the child is currently taking; Does? _____
_____
4. Has your child ever had surgery or been hospitalized? Explain. _____
_____
5. Child's Physician: _____ Phone #: (____) _____
6. Are your child's immunizations current? Y N
7. Please describe the child's current physical health. Good Fair Poor

Dental History

What is the reason for your chld's dental visit? _____
Has your child ever been to the dentist? _____ Any unhappy dental experiences? _____
Previous dentist's name _____ Has your child ever had dental x-rays? Date? _____
Have your child's teeth ever been injured? When? How? _____
How do you expect your child to react in the dental chair today? Good Fair Poor
Do you assist/supervise your child's brushing? _____ How often? _____
Do you or your child use dental floss? _____ How often? _____
Was your child bottle fed / breast fed? Has your child been weaned? When? _____
Does your child have snacks between meals? Y N Is your home water supply fluoridated? Y N
Any oral habits: thumb, finger, or pacifier habit? Y N Does your child use a fluoride toothpaste? Y N
Does your child use a fluoride supplement?

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 tit is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian **Relationship to Patient**

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials _____ Date _____
Doctor's Comments _____
_____
_____
_____