

Catherine V. Marcantonio, DMD  
Specialist in Pediatric Dentistry

Michael H. Marcantonio, DMD  
General Dentistry



842 Hwy 20 E, Suite 102 Freeport, FL 32439 • 850-835-5437

### 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/Rubber 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 child'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 it 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 \_\_\_\_\_