Patient Registration
(Child)

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Pref. Dentist: ______

Pref. Pharmacy: ______

Pref. Hyg: ______

Section 3

Father's Name ______

Father's Employer ______

Mother's Name ______

Mother's Employer ______

Physician ______

Primary Dental Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Secondary Dental Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Jennifer A Kennedy, DDS, LLC

Eaglesoft Medical History-Child

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Question	Answer	
Is your child under a physician's care now?	Yes No	If yes
Has your child ever been hospitalized or had a major operation?	Yes No	If yes
Has your child ever had a head or neck injury?	Yes No	If yes
Has your child ever had Oral Surgery?	Yes No	If yes
Has your child ever had Orthodontics?	Yes No	If yes
Does your child use tobacco?	Yes No	

Female Patients: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

Other? If yes

Does your child use controlled substances? Yes No If yes

Emergency Information:

Please list below names, relationships and contact phone numbers of person(s) to notify in case of an emergency.:

Please state below the name and phone number of your Physician:

Does your child have, or has your child had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Anaphylaxis	Yes No	Anemia	Yes No	Artificial Heart Valve	Yes No
Artificial Joint	Yes No	Asthma	Yes No	Blood Disease	Yes No	Cancer	Yes No
Chemotherapy	Yes No	Cold Sores/Fever Blister	Yes No	Congenital Heart Disorder	Yes No	Cortisone or Steroids	Yes No
Diabetes	Yes No	Drug Addiction	Yes No	Emphysema/COPD	Yes No	Epilepsy/Seizures	Yes No
Fainting/Dizziness	Yes No	Frequent Headaches	Yes No	Heart Attack/Failure	Yes No	Heart Pacemaker	Yes No
Hemophilia	Yes No	Hepatitis A,B,C	Yes No	Herpes	Yes No	High/Low Blood Pressure	Yes No
High Cholesterol	Yes No	Hypo-glycemia	Yes No	Kidney Problems	Yes No	Liver Disease	Yes No
Lung Disease	Yes No	Pain in Jaw Joints	Yes No	Thyroid/Parathyroid Problems	Yes No	Psychiatric Care	Yes No
Radiation Treatments	Yes No	Renal Dialysis	Yes No	Sleep Breathing Disorder	Yes No	Ulcers	Yes No
Temporal Arteritis	Yes No	Sexually Transmitted Diseases	Yes No				

Have you had any serious illness not listed above? Yes No If yes

Comments:

Medications

Is your child taking any medications, pills, or drugs? ◯ Yes ◯ No

Please list below:
Name of Medication, Dose, Frequency and Reason for taking:

Dental History

When did your child last see a dentist?

Name of Dentist:

Please list any unfavorable experiences that your child may have had in a dental office:

Please describe any recent dental discomfort your child might be having:

Who may we thank for referring your child to this office?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Guardian:

X

Date:__________