Child Registration

Date_____ Patients Date of Birth _____ Age_____ Male / Female School/Grade_____

Patient Name_____SS#_____Home Phone _____

Home Address _____City_____State _____Zip_____

Father's Name _____ Address _____ Wk Ph_____

Mother's Name _____ Address _____Wk Ph_____l_____

Mom Cell_____**Dads Cell**_____ Do you have dental insurance? _____

Person Responsible for Account: _____SS#_____ Employer_____ Wk Phone_____

Home Address _____ City_____ State _____Zip _____ Hm Phone_____

Nearest Relative **NOT** living with you _____ Home/Cell Phone_____

Address _____City _____ State _____ Zip _____

Referred by : _____

Medical History

Child Physician_____Address_____ Phone_____

Date of last complete physical examination? _____ Results _____

Is your child presently under the care of a physician ? _____ For_____

Is your child taking any medications or drugs? _____ Please list _____

Has your child ever had any adverse reactions to any drugs?(i.e.Penicillin,aspirin)_____

What is your child's weight? _____ Height (aprox.)?_____ Are your child's immunizations up to date?_____

Has your child ever been hospitalized/had surgery? _____ For _____

Any injuries to mouth, teeth, or head? _____ Explain _____

Child attitude to dentistry?_____

Are there any psychological or emotional problems you would like us to know about? _____

Please place a check next to any of the following that apply to the patient

_____ Rheumatic fever ____ Rheumatic heart disease _____ Heart murmur _____Asthma _____ Arthritis _____ Diabetes

_____ Blood sugar problems _____ bleeding issues _____ bruises easily _____ Kidney disease_____ Bladder problems _____ Anemia

_____ Tuberculosis _____ Hepatitis _____ Aids/ HIV/ARC _____ Hormonal problems _____ Convulsions, epilepsy _____ High/low blood pressure

_____ speech, hearing disorder _____ Childhood illness _____ Mitral valve prolapse

Date of last dental visit_____ For What _____ by DR._____

Any lost teeth other than loosing baby teeth?_____ Does your child brush daily? _____

Do you assist with brushing? _____ Is dental floss used? ____ Are discoloring tablet used? _____

Eating habits presently- briefly explain _____

How does your child receive fluoride? (**Circle**) water supply toothpaste dentist vitamins tablets none other _____

Any mouth habits (Thumbsucking, nail biting, mouth breathing?_____

I consent to treatment for the above named patient. I authorize the release, via fax, phone & internet if necessary, of all medical or dental records, Including any and all records containing HIV and substance abuse, to my insurance company.

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medicines, I will inform the doctor at the next appointment.

Signed: _____Relation to Patient _____ Date : _____

I agree to pay all charges for treatment and understand that payment is due at the time of services. I hereby assign all dental benefits, including major dental benefits to which I am entitled, private insurance and other insurance plans to the provider. I further authorize and request insurance payments to be made directly to Patrick Guidry D.D.S. . **I understand I am responsible for all charges not paid by my insurance company. If we are forced to turn your balance over to a collection agency, you will be responsible for the collections and attorney fees, including court costs.** All NSF checks will be subject to a $45.00 return check fee. This assignment will remain in effect until revoked by me in writing.

A service charge of 1.5% per month or 18% annually will be charge after 90 days.

Signed : _____ Relation to Patient _____ Date: _____