ARLINGTON DENTAL CENTER
931 ARLINGTON
ADA, OK 74820

CHILD PATIENT REGISTRATION

CHILD'S NAME: _____ SEX: _____ Date of Birth _____

Age _____ Height _____ Weight _____ Social Security # _____

Address: _____ City _____ State _____ Zip _____

HomeTelephone(___)_____Hobbies/Interests_____

Who is responsible for making appointments? _____

In EMERGENCY NOTIFY: Name, Address, Phone Number and relationship to patient: _____

_____

PARENT INFORMATION

Father or Guardian Name _____ Date of Birth _____ SS# _____

Address _____ Phone _____

Employed by: _____Business Phone: _____

Cell Phone: _____ E-Mail _____Marital Status: _____ Spouse Name _____

Mother or Guardian Name _____Date of Birth _____ SS# _____

Address _____ Phone _____

Employed by: _____Business Phone:_____

Cell Phone:_____ E-Mail_____ Marital Status: _____ Spouse Name _____

Referred By: Patient _____Dentist_____ Phone Book___

Friend_____Relative _____

INSURANCE INFORMATION

Is child covered by dental insurance? Yes _____ No _____

PRIMARY INSURANCE : INSUREDS RELATIONSHIP TO PATIENT_____

INSURED (who has the insurance?) _____ EMPLOYER: _____

INSURANCE COMPANY _____ POLICY # _____GROUP # _____

INSURED'S BIRTH DATE _____INSURED'S SOCIAL SECURITY NUMBER _____

SECONDARY INSURANCE : INSURED'S RELATIONSHIP TO PATIENT_____

INSURED (who has the insurance?) _____ EMPLOYER: _____

INSURANCE COMPANY _____ POLICY # _____GROUP # _____

INSURED'S DATE OF BIRTH _____INSURED'S SOCIAL SECURITY NUMBER _____

RESPONSIBLE PARTY

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT OF DENTAL ACCOUNT FOR THE ABOVE NAMED PATIENT. PAYMENT IS EXPECTED AT TIME OF SERVICE. ESTIMATED INSURANCE BENEFITS IS NOT A GUARANTEE OF INSURANCE PAYMENT. I UNDERSTAND I AM RESPONSIBLE FOR THIS ACCOUNT INCLUDING ANY AMOUNT INSURANCE DOES NOT PAY.

SIGNED: _____ DATE _____

FINANCE CHARGE: 1.5% PER MONTH ON PAST DUE ACCOUNTS. 18% ANNUAL PERCENTAGE RATE

_____

FOR UPDATING ON SUBSEQUENT VISITS ONLY:

1	2	3	4	5
INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE

6	7	8	9	10
INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE	INITIALS DATE

ARLINGTON DENTAL CENTER
BRUCE A. HALL, DDS
931 ARLINGTON, ADA, OK 74820

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME_____PATIENT HEIGHT_____PATIENT WEIGHT _____

PLEASE ANSWER BY CIRCLING EITHER YES OR NO TO THE FOLLOWING QUESTIONS OR CHECKING THE APPROPRIATE ITEMS

(Answers to the following questions are for our records only and will be kept confidential)

YES NO 1. Are you in good health? _____
YES NO 2. Have there been any changes in your general health over the past year? _____
3. My last physical examination was on _(date)_____
YES NO 4. Are you now under the care of a physician? _____
5. If so, what condition are you being treated for? _____

Name, address, phone number of your physician _____

YES NO 6. Have you had any serious illness or operation? _____

7. **CHECK** any of the following which you have had or have at present:

__Allergies
__Arteriosclerosis
__Arthritis
__Asthma
__Blood Transfusion
__Cancer
__Congenital heart lesions or HEART MURMUR
__Diabetes
__Emphysema
__Fainting spells or Seizures
__Hay Fever
__Heart disease or Attack
__Heart Failure
__Heart Pacemaker
__Heart Surgery
__Hepatitis
__High blood pressure
__HIV Positive, AIDS
__Hives or Skin rash
__Inflammatory Rheumatism (painful swollen joints)
__Jaundice
__Kidney trouble
__Liver disease
__Low Blood Pressure
__Prosthetic joint replacement surgery
__Rheumatic fever or Rheumatic heart disease
__Stomach Ulcers
__Stroke
__Tuberculosis
__Venereal disease
__Any other we need to know about? _____
_____
___None

YES NO 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? _____

YES NO 9. Do you bruise easily? _____

YES NO 10. Do you have any blood disorder such as anemia? _____

YES NO 11. Have you had surgery or x-ray treatment for a tumor, growth or other condition of the head or neck? _____

YES NO 12. Are you taking or HAVE YOU EVER TAKEN Fen-phen (Pondimin or Redux)? _____

(OVER)

13. **CHECK** any of the following that you are taking:

__Antibiotics or Sulfa drugs?
__Anticoagulants (blood thinner)
__Antihistamines
__Aspirin
__Cortisone (steroids)
__Digitalis or drugs for heart trouble
__Fen-phen or any other diet drug
__Insulin, Tolbutamide (Orinase) or similar drug
__Medicine for high blood pressure
__Nitroglycerine
__Oral Contraceptives or hormone therapy. **Note:**
Antibiotics may render oral contraceptives ineffective.
__Tranquilizers
__None

List any other drugs you are taking_____

_____

14. **CHECK** any of the following that you are ALLERGIC to or have REACTED ADVERSELY to:

__Local anesthesia _____
__Penicillin or other antibiotics_____
__Sulfa drugs_____
__Barbiturates, sedatives, or sleeping pills_____
__Aspirin_____
__Iodine_____
__Codeine or other narcotic_____
__Latex_____
__None

List any other **medications or metals** you are allergic to:_____

YES NO 15. Have you had any trouble associated with any previous dental treatment? _____
YES NO 16. Have you ever required pre-medication for any previous dental treatment? _____
YES NO 17. Do you have any disease, condition, or problem not listed that you think we should know of? If so, what?
_____
YES NO 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? _____
YES NO 19. Are you wearing contact lenses? _____
YES NO 20. Do you smoke? _____
YES NO 21. Do you use alcohol on a regular basis? _____
YES NO 22. WOMEN: Are you pregnant? _____
YES NO 23. Do you take or have you taken Fosamax, Boniva,Actonel or other drug containing Bisphosphonates_____

PURPOSE OF THIS CALL: _____

PREVIOUS DENTIST: _____ CITY_____

X_____

PATIENT, PARENT, OR GUARDIAN SIGNATURE DATE_____
(CIRCLE ONE)

_____

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