HABERSHAM FAMILY DENTAL

NEW PATIENT REGISTRATION

TELL US ABOUT YOUR CHILD

Child's Name_____

Preferred Name _____ ☐ Male ☐ Female

Child's DOB _____ /_____ /_____ Age _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

List any hobbies, interest or activities _____

_____

CONTACT INFORMATION

Best Contact Number _____

Alternative Number _____

Email _____

What is your appointment confirmation preference (please check all that apply):

☐ Text ☐ Phone ☐ Email

RESPONSIBLE PARTIES

Insurance Subscriber's Information

Name _____ ☐ Male ☐ Female
☐ Parent ☐ Stepparent ☐ Legal Guardian

Birth Date _____/_____/_____ SSN _____

Employer _____

Insurance Co. Name _____

Insurance Phone _____

Insurance Identification # _____

Secondary Dental Insurance (if applicable)

Insurance Co. Name _____

Insurance Phone _____

Insurance Identification # _____

Additional Party Information

Name _____ ☐ Male ☐ Female
☐ Parent ☐ Stepparent ☐ Legal Guardian

Birth Date _____/_____/_____ SSN _____

Employer _____

HOW DID YOU HEAR ABOUT US?

Please List Name(s) of Referral Source

_____

_____

AUTHORIZATION & ACKNOWLEDGEMENTS

Please initial.

_____ I give permission to Dr. McShane and his appointed representatives to release any information to use my address, phone number and clinical records to contact me with information about treatment or other health related information, referrals and testimonies.

_____ I authorize and request my insurance company to pay insurance benefits directly to my dentist, if that option is available under my plan. I understand that my dental insurance carrier may pay less than the actual bill for services or the estimate and that any additional amounts due are my responsibility. Any insurance claim not paid within 60 days of filing becomes my immediate responsibility. As a service to me, Dr. McShane's office will continue to provide me with any documentation requests from the insurance company so I may continue to pursue collection of my benefits.

_____ I understand that fees are due at the time of service unless previous arrangements have been made. A carrying charge of 1.5% per month may be added to account balance over 60 days old.

_____ I authorize Dr. McShane and his appointed representatives to release any information including the diagnosis and the records of any treatment or examination rendered to my child to other health providers and/or third party payers.

DENTAL HISTORY

Why did you bring your child to the dentist today? _____

_____

Is this your child's first visit to the dentist? Yes ☐ No ☐

If not, when was their last visit to the dentist? _____

Previous Dentist _____

Were x-rays taken at previous dental visits? Yes ☐ No ☐

Has your child had a toothache recently? Yes ☐ No ☐

Have there been any injuries to the teeth, face, or mouth? If

yes, please explain_____

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does your child have any of the following habits?

☐ Thumb/Finger Sucking ☐ Mouth Breathing

☐ Lip Sucking/Biting ☐ Nail Biting

☐ Bottle Habits ☐ Pacifier Use

Has your child ever had a serious or difficult problem associated with previous dental work? ☐ Yes ☐ No

If yes, please explain_____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No

Who brushes your child's teeth? _____

Do you have city or well water? _____

HEALTH HISTORY

Child's Primary Care Physician_____

Telephone number _____

Please answer YES or NO to all the following questions.

Does your child have any serious or chronic illnesses? □ Y □ N

Explain_____

Has your child had serious injuries or accidents? □ Y □ N

Explain_____

Has your child had any surgeries? □ Y □ N

Explain_____

Has your child ever been hospitalized? □ Y □ N

Explain_____

Has your child ever reacted to immunizations? □ Y □ N

Explain_____

List all medications your child is currently taking _____

_____

_____

List all allergies:

- ❑ Latex materials
- ❑ Penicillin or other antibiotics_____
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Aspirin
- ❑ Other _____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	□ Y □ N
Nasal allergies or eczema	□ Y □ N
Frequent ear infections or sore throat	□ Y □ N
Problems with ears or hearing	□ Y □ N
Problems with eyes, vision	□ Y □ N
Frequent headaches or other neurologic problems	□ Y □ N
Frequent abdominal pain	□ Y □ N
Constipation requiring doctor visits	□ Y □ N
Bladder/kidney problems or bedwetting	□ Y □ N
Any heart problems/murmur	□ Y □ N
Thyroid or other gland problem	□ Y □ N
Diabetes	□ Y □ N
ADD/ADHD	□ Y □ N
Mental Health Issues	□ Y □ N
Autism, PDD-NOS and Asperger's	□ Y □ N

COMPLETE REGISTRATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in 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 at *Habersham Family Dental* to perform the necessary dental services my child may need.

_____

Parent/Guardian Name

_____

Parent/Guardian Signature