

# PATIENT REGISTRATION

## Patient Information

Account No. \_\_\_\_\_

Patient's Last Name		First Name	Middle Initial	Social Security #
Nickname	Sex	Birthdate (Mo., Day, Year)	Number of Brothers	Number of Sisters
Street Address		City, State, Zip Code		(Area Code) Home Phone

## Father's Information

Father's Last Name		First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address (If different than patient)		City, State, Zip Code		(Area Code) Home Phone #
Employed By	Job Position	Business Address		(Area Code) Cell Phone #
Father's Social Security #	Father's Dental Insurance			(Area Code) Business Phone #
Group #	Insurance ID#	Email		

## Mother's Information

Mother's Last Name		First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address (If different than patient)		City, State, Zip Code		(Area Code) Home Phone #
Employed By	Job Position	Business Address		(Area Code) Cell Phone #
Mother's Social Security #	Mother's Dental Insurance			(Area Code) Business Phone #
Group #	Insurance ID#	Email		

## Step Parent, Guardian or Other Insurance Carrier

Last Name		First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address (If different than patient)		City, State, Zip Code		(Area Code) Home Phone #
Employed By	Job Position	Business Address		(Area Code) Cell Phone #
Social Security #	Dental Insurance			(Area Code) Business Phone #
Group #	Insurance ID#	Email		
Relationship to Patient				

OVER

## Emergency Information

Person to be reached in case of emergency, other than parent:

Name	Relationship to Patient	(Area Code)Phone Number
Name	Relationship to Patient	(Area Code)Phone Number

## Consent For Treatment Of A Minor

Because your child is a minor, signed permission is required from a parent or legal guardian before any dental services can be rendered. By signing your consent below, you are giving the Doctors permission to perform a dental examination including x-rays (periapical, bitewing, occlusal, panoramic, and/or cephalometric, radiographic films), photographs, and/or models. This authorization also includes all necessary treatment, medications and therapy indicated for the dental care of your child, including local anesthetic and nitrous oxide analgesia as indicated by the doctor. The doctors are also given permission to use their professional judgement in patient management regimes as they feel necessary.

I understand that, at any time, I have questions I may speak to the doctor treating my child. I understand I can ask questions until I have received satisfactory answers to those questions.

I authorize release of information to my insurance carrier. I authorize payment directly to the doctor from my insurance carrier.

I understand and agree that, (regardless of my insurance status), I am responsible for the balance on my account at the time professional services are rendered. I understand it is my responsibility to pay all fees not covered by my insurance. I understand it is my responsibility to pay all costs associated with collection of unpaid and overdue balances including the costs associated with collection agencies should such action be indicated. I have read all of the information and have completed this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes. I certify by signing this, I am the minor's legal parent or guardian.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

DENTAL ASSISTANT \_\_\_\_\_

# Medical History

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Family Physician or Pediatrician \_\_\_\_\_ Office Phone Number \_\_\_\_\_

Family Dentist \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Does your child have any dental complaints? \_\_\_\_\_

General health of the patient? (please check)     Excellent     Good     Fair     Poor

Last complete physical? \_\_\_\_\_ Findings? \_\_\_\_\_

Is your child presently under the care of a physician?     Yes     No

Has your child had any serious operations, illnesses, injuries and/or hospitalizations?     Yes     No

If yes, please list dates and reasons \_\_\_\_\_

Is your child taking any medication now?     Yes     No    If yes, please list the names of the medication, dosage and purpose: \_\_\_\_\_

Is your daughter taking any form of Contraceptive Medication ( i.e., birth control pills) at this time?

(Prescription of certain antibiotics may interfere with the effectiveness of the birth control

medication.)     Yes     No    Is your daughter pregnant?     Yes     No

Is your child allergic to:

- |                              |                              |                        |                              |                             |                   |
|------------------------------|------------------------------|------------------------|------------------------------|-----------------------------|-------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No  | Latex                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Codeine           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No. | Penicillin/Amoxicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Local anesthetics |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No  | Sulfa medications      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other? _____      |

Does your child have a history of any of the following?

- |                              |                             |                            |                              |                             |                            |
|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart murmur               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart disease/disorders    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stomach/GI problems        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic fever            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer/tumors              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abnormal blood pressure    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chemotherapy/ radiation    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood disorders/dyscrasias | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological disorders     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recurrent headaches        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prolonged bleeding         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy/Seizures          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bruise easily              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin disease/disorders     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood transfusion          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bacterial/viral infections |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung disease               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | STD's/ Herpes              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS/HIV                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory infections     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anorexia/Bulimia           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Coughing                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Congenital birth defects   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cleft lip/Cleft palate ;   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus trouble              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ADD/ADHD                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergies                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Autism                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney/bladder disease     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental impairment          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver disease              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Developmental delays       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Learning problems          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emotional problems         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pancreatic disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Physical handicaps         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Endocrine disorders        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vision problems            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid disorder           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing problems           |

If **yes**, to any of the disorders listed any other disease, condition, or problem not listed please **explain fully** on back: