REGISTRATION

PATIENT'S NAME: _____ NICKNAME _____

Patient's Address: _____ Zip _____
Patient's Phone #: _____
Date of Birth: _____ Male ____ Female ____
Email: _____
Patient's SS#: _____

Mother's Name: _____ D.O.B _____
Mother's Address: _____ Zip _____
Mother's Phone #: H: _____ W: _____
Mother's SS#: _____
Mother's Employer: _____
Cell: _____
Mother's Drivers License #: _____
May we contact Mother at work? Y or N

Father's Name: _____ D.O.B _____
Father's Address: _____ Zip _____
Father's Phone #: H: _____ W: _____
Father's SS#: _____
Father's Employer: _____
Cell: _____
Father's Drivers License #: _____
May we contact Father at work? Y or N

Child Lives With:
_____ Both Parents _____ Mother _____ Father
_____ Other: _____

Are you the Biological Parent? Y or N
Are you the Custodial Parent? Y or N

Legal Guardian: (if applicable)
Guardian's Name: _____
Guardian's Address: _____
Guardian's Phone #: Home _____ Work _____
Guardian's SS#: _____
Guardian's Drivers License #: _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name: _____
Employee Date of Birth: _____
Employer: _____
Name of Insurance Co.: _____
Group or Policy #: _____
Employee SS#: _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name: _____
Employee Date of Birth: _____
Employer: _____
Name of Insurance Co.: _____
Group or Policy #: _____
Employee SS#: _____

In Case of Emergency: (if we cannot contact parents)
Please Contact: _____
Phone #: _____

Referral Doctor: _____
(if applicable)

Parental consent is necessary on pediatric patients; legally they are minors. Diagnosis of services needed will be discussed with the doctor before any treatment is rendered.

Your signature authorizes the doctor to render dental services, medications and behavior therapy as needed and to employ such assistance as he deems fit.

RELEASE:

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on these two pages.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist?_____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ..... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth? ❑ Upon arising
   ❑ After eating any food ❑ Right after meals ❑ Before going to bed
7. How does your child receive Fluoride?
   ❑ Community water ❑ Well water ❑ Bottled water
   ❑ Fluoride drops or tablets ❑ Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Is there anything about your child our office should know to better plan his/her dental treatment?_____
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
    If so, describe_____
11. Has your child had any problem with dental treatment in the past? ..... YES NO
12. Has anyone in the family, including parents, had orthodontics? ..... YES NO
13. Has your child ever received a local anesthetic? ..... YES NO
14. Has your child ever had sealants? ..... YES NO
15. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? ..... YES NO
2. Is your child under the care of a physician? ..... YES NO
   If yes, since when and why?_____
3. Name of physician _____
   Phone_____
4. Is your child receiving any medication? ..... YES NO
   What?_____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Does you child have other allergies? ..... YES NO
7. Has your child had any serious illness? ..... YES NO
   When _____ What_____
8. Has your child ever had surgery? ..... YES NO
9. Does your child have a heart murmur? ..... YES NO
10. Is your child current with his/her immunizations? ..... YES NO
11. Does your child experience severe or prolonged bleeding? ..... YES NO
12. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
13. Has your child tested positive for hepatitis? ..... YES NO
14. Is your child subject to nervous disorders ..... YES NO
    ❑ Fainting ❑ Seizures ❑ Dizziness? ❑ Behavioral/Learning problems?
15. Does your child have frequent headaches? ..... YES NO
16. Has your child had history of (*Circle appropriate responses.*) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, intellectual or developmental disability , eyesight problems, cancer, infections, speech impairments, hearing loss.

please turn over and complete the back page