PATIENT REGISTRATION

Patient Information

Patient Last Name:_____ First Name:_____ Middle Initial:_____

Nickname:_____ Sex: _____ Birthday: (Mo./Day/Year)_____/_____/_____

Number of Brothers:_____ Number of Sisters:_____Social Security #:_____

Street Address:_____

City, State, Zip Code:_____ Home Phone:(_____)_____

Father's Information

Father's Last Name:_____ First Name:_____ Middle Initial:____ Birthday: (M/D/Yr)____/____/_____

Street Address:_____

City, State, Zip Code:_____ Home Phone:(_____)_____

Employed By:_____ _____ Job Position:_____

Business Address:_____ Business Phone:(_____)_____

Father's SSN#:_____ Father's Dental Insurance:_____

Group#:_____ Date Insurance Effective _____/_____/_____

Mother's Information

Mother's Last Name:_____ First Name:_____ Middle Initial:____ Birthday: (M/D/Yr)____/____/_____

Street Address:_____

City, State, Zip Code:_____ Home Phone:(_____)_____

Employed By:_____ _____ Job Position:_____

Business Address:_____ Business Phone:(_____)_____

Mother's SSN#:_____ Mother's Dental Insurance:_____

Group#:_____ Date Insurance Effective _____/_____/_____

Primary Insurance

Name of Primary Insurance : _____

Contract #: _____ Group #: _____

Person Responsible for Account : _____ Relation to Patient: _____Date of Birth:____/____/_____

Secondary Insurance

Name of Secondary Insurance : _____

Contract #: _____ Group #: _____

Person Responsible for Account : _____ Relation to Patient: _____Date of Birth:____/____/_____

Consent of Service

I hereby authorize payment directly to the dental office of the group insurance benefits, otherwise payable to me. I understand that I am responsible for all cost of dental treatment that the insurance company doesn't cover. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedure as may be necessary for proper dental care for a my child

AUTHORIZATION FOR TREATMENT OF A MINOR

Because your child is a minor, signed permission is required from a parent or guardian before any dental service can be rendered. The doctors are given permission to use their professional judgment in patient management regimes as they feel necessary. This authorization include radiographs, photographs, and all necessary treatment.

Please be advised that all reschedule appointment must be done at least 24 hours before you schedule appointment time

_____ _____

Signature: Parent / Legal Guardian Date

Medical History

Patient's Name:_____Date_____ 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 complains? _____

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 operation, 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:

[ ]Yes [ ]No Latex
[ ]Yes [ ]No Pencillin/Amoxicillin
[ ]Yes [ ]No Sulfa medications
[ ]Yes [ ]No Codeine
[ ]Yes [ ]No Local anesthetics
[ ]Yes [ ]No Other?_____

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

[ ]Yes [ ]No Heart murmur
[ ]Yes [ ]No Heart disease/disorders
[ ]Yes [ ]No Rheumatic fever
[ ]Yes [ ]No Abnormal blood pressure
[ ]Yes [ ]No Blood disorder/dyscrasias
[ ]Yes [ ]No Anemia
[ ]Yes [ ]No Prolonged bleeding
[ ]Yes [ ]No Bruise easily
[ ]Yes [ ]No Blood transfusion
[ ]Yes [ ]No Lung disease
[ ]Yes [ ]No Tuberculosis
[ ]Yes [ ]No Respiratory infections
[ ]Yes [ ]No Coughing
[ ]Yes [ ]No Asthma
[ ]Yes [ ]No Sinus trouble
[ ]Yes [ ]No Allergies
[ ]Yes [ ]No Liver disease
[ ]Yes [ ]No Hepatitis
[ ]Yes [ ]No Jaundice
[ ]Yes [ ]No Pancreatic disorders
[ ]Yes [ ]No Endocrine disorders
[ ]Yes [ ]No Thyroid disorder
[ ]Yes [ ]No Kidney/bladder disease
[ ]Yes [ ]No Diabetes
[ ]Yes [ ]No Stomach/GI problems
[ ]Yes [ ]No Cancer/tumers
[ ]Yes [ ]No Chemotherapy / radiation
[ ]Yes [ ]No Neurological disorder
[ ]Yes [ ]No Recurrent headaches
[ ]Yes [ ]No Epilepsy/Seizures
[ ]Yes [ ]No Skin disease/disorder
[ ]Yes [ ]No Bacterial/viral infections
[ ]Yes [ ]No STD's/Herpes
[ ]Yes [ ]No AIDS/HIV
[ ]Yes [ ]No Anorexia/Bulimia
[ ]Yes [ ]No Congenital birth defects
[ ]Yes [ ]No Cleft lip/Cleft palate
[ ]Yes [ ]No Developmental delays
[ ]Yes [ ]No Learning problems
[ ]Yes [ ]No Emotional problems
[ ]Yes [ ]No Physical handicaps
[ ]Yes [ ]No Vision problems
[ ]Yes [ ]No Hearing problems

IF YES, TO ANY OF THE DISORDERS LISTED ANY OTHER DISEASE, CONDITION, OR PROBLEM NOT LISTED PLEASE EXPLAIN FULLY ON BACK:

Please Continue in the back --->

Comments:

Signature: Parent / Legal Guardian Date

Signature: Parent / Legal Guardian Date

Signature: Parent / Legal Guardian Date

Signature: Parent / Legal Guardian Date

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Signature: Parent / Legal Guardian Date