

Welcome



Patient Registration Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. TELLS US ABOUT YOUR CHILD

Child's Name: First _____ Last _____ Mi. _____
Nickname: _____ Male Female
Child's Birthdate ____/____/____ Child's Age _____ SSN: _____
Child's Home Address: _____
City _____ State _____ Zip _____
Child's Home # (____) _____
School _____ Grade _____
Siblings that we treat _____

2. MOTHER'S INFORMATION

Name: First _____ Last _____ Mi. _____
Mother Stepfather Guardian Birthdate ____/____/____
Employer _____ Work # (____) _____ Ext. _____
Home # (____) _____ Cellular # (____) _____
SS # _____ DL # _____
Email Address _____

3. FATHER'S INFORMATION

Name: First _____ Last _____ Mi. _____
Father Stepfather Guardian Birthdate ____/____/____
Employer _____ Work # (____) _____ Ext. _____
Home # (____) _____ Cellular # (____) _____
SS # _____ DL # _____
Email Address _____

4. WHO IS ACCOMPANYING THE CHILD TODAY?

Name: First _____ Last _____ Mi. _____
Relationship _____
Do you have legal custody of the child? Yes No

5. PERSON RESPONSIBLE FOR ACCOUNT

Name: First _____ Last _____ Mi. _____
Relationship _____
Work # (____) _____ Ext. _____ Home # (____) _____
Cellular # (____) _____ Email Address _____
Billing Address: _____
City _____ State _____ Zip _____

6. PRIMARY DENTAL INSURANCE

Insurance Co. Name _____ Insurance Co. Phone # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Policy Holder's Name: First _____ Last _____ Mi. _____
Policy Holder's Birthdate ____/____/____ SS # _____
Policy Holder's Employer _____
Relationship to Patient _____

7. WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Medical History



Child's Name _____ Nickname _____
Date of Birth _____ Weight _____ Last physical exam _____ Last immunizations _____ Pregnant Y/ N
Primary Care Provider _____ Phone _____
Specialist _____ Phone _____

1. Does your child have any major health problems? Y/ N If yes, explain _____
2. What medications is your child currently taking? What For? _____
3. Was your child born premature? Y/ N If yes, explain _____
Weeks of gestation? _____ Birth Weight? _____
Was a feeding tube used? Y/ N How long? _____
Was a breathing tube used? Y/ N How long? _____
4. Has your child been hospitalized? Y/ N If yes, explain _____
5. Has your child ever had surgery? Y/ N If yes, explain _____
6. Does your child have a heart murmur or heart defect? Y/ N If yes, explain _____
Was the murmur present at birth? Y/ N
Type of murmur? _____
Does your child have a heart card? Y/ N
Has your child been seen by a cardiologist? Y/ N When? _____
When is the next cardiology appointment? _____
Does the child require antibiotics for heart? Y/ N
Has your child had heart surgery or need heart surgery? Y/ N

7. Is your child currently being treated by a physician? Y/ N If yes, explain _____
8. Does your child suffer from allergies? Y/ N If yes, explain _____
9. Has your child ever experienced an unfavorable reaction? Y/ N If yes, please explain below

Please circle:

Drugs	Antibiotics	Foods	Lactose intolerant
Metals	Local Anesthetics	Dyes	Acrylic Latex
Other _____			
Rash? Y/ N	Treatment? Y/ N	Hives? Y/ N	Treatment? Y/ N
Anaphylaxis? Y/ N	Treatment? Y/ N		

10. Does your child have Asthma? Y/ N
Last Asthma attack? _____
What causes an attack? _____
Has your child ever been hospitalized for Asthma? Y/ N
Medications for Asthma? _____

11. Does your child have diabetes? Y/ N
How long have they been a diabetic? _____
Type I or II Medication _____
Frequency? _____

12. Has your child ever undergone general anesthesia? Y/ N If yes, explain _____
13. Does your child have a history of developmental or behavior problems? Y/ N If yes explain below

Please circle:

ADD ADHD OCD ODD Depression Autism Other _____

14. Has or does your child have a history or difficulty with any of the following?
Please circle:

AIDS	High Blood Pressure	Cancer	Tuberculosis	Ulcers	Heart
Liver	Hepatitis	Anemia	Seizures/ Epilepsy	RSV	Bleeding Disorders
Arthritis	Rheumatic Fever	Autism	Speech Impairment	Chronic Sinus	Down Syndrome
Visual Impairment	Head Ache	Cerebral Palsy	Ears/ Hearing	Snoring or Sleep Apnea	Bladder Infections
Smoking	Tonsils/ Adenoids	Cystic Fibrosis	Obesity	Eczema	Under Weight
Thyroid	Kidneys	Eating Disorders	Cleft lip/ Cleft Palate		

Dental History

Date of Last Dental Visit: _____ Dentist Name: _____
 Services Rendered: _____ Were x-rays taken? Y/ N

15. Does your child have any dental complaints? Y/ N If yes, explain _____
 16. Does your child have any swelling or infection in the mouth? Y/ N If yes, explain _____
 17. What was your child's behavioral response to past dental care? _____
 18. What is your child's attitude towards dentistry? _____
 19. Are YOU anxious about the Dentist? Y/ N When was YOUR last check-up? _____ Do YOU have cavities? Y/ N
 20. Does your child play sports? Please list: _____ Does your child wear a mouth guard? Y/ N
 21. Does your child play a musical instrument? If yes, please list? _____
 22. Any injuries to the teeth, mouth, TMJ, or head? Y/ N If yes, explain _____
 When did the injury happen? _____ Did you receive emergency dental care? Y/ N

24. Has your child had any of the following?

- | | | | |
|--------------------|--------------------|-------------|---------------|
| Bruxism (Grinding) | TMJ/Joint Problems | Snoring | Thumbsucking |
| Lip Biting | Pacifier | Nail biting | Fingersucking |
| Nursing | Bottle | | |

25. Does your child brush daily? Y/ N How often? _____ Do you assist? Y/ N
 26. Does your child floss? Y/ N How often? _____ Do you assist? Y/ N
 27. Is fluoride taken? ___ Water ___ Toothpaste ___ Chewable tablets ___ Rinse ___ Fluoride drops (strength) _____
 28. Is your city on ___ city or ___ well water? If well water, what is the fluoride content? _____

29. Does your child use any of the following?

Please circle:

Sippy cup

Bottle

Nursing

If so, how often? _____ What is in the bottle or sippy cup? _____

30. Does your child drink any of the following?

Please circle:

Soda

Kool Aid

Juice

Sports drinks

Milk

Water

If so, how often? _____

31. Does your child snack between meals? Y/ N If yes, what types of snacks? _____ Candy _____
 32. Do you desire complete dental services for your child? Y/ N If no, explain _____

ACKNOWLEDGMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I certify that I am legally qualified to provide the above information. I am the child's (please circle) mother, father, grandfather, grandmother, foster parent, or other. You must provide documentation that you are legally able to sign this form.

Parent's Name: _____ Date: _____

Child's Name: _____ D.O.B: _____

STAFF REVIEW: