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PATIENT REGISTRATION

Date_____

1. Tell Us About Your Child

Child's First Name_____Middle Initial_____Last Name_____
Nickname (if any)_____Date of Birth_____ □ Male □ Female
What are your child interests/hobbies?
_____
Social Security #_____Home Phone _____
Home Address_____
City_____State_____
ZIP_____
Email_____

2. Mother's/Guardian's Information

Name: _____
Birth Date:_____
Home Phone: _____
Cell Phone:_____
Address: _____
City: _____
State:_____Zip:_____
Employer: _____
Email: _____

3. Father's/Guardian's Information

Name:_____
Birth Date: _____
Home Phone: _____
Cell Phone:_____
Address: _____
City: _____
State:_____Zip:_____
Employer: _____
Email: _____

4. Who Is Accompanying the Child Today?

Name: _____
Relationship:_____
Do you have legal custody of this child?
□ Yes □ No

5. Responsible Party Information

Name:_____
Birth Date: _____
Home Phone: _____
Cell Phone:_____
Address: _____
City: _____
State:_____Zip:_____

6. Primary Dental Insurance

Insurance Company Name

_____

Insurance Company Address

_____

Insurance Company
Phone#_____

Group # (Plan, Local, or Policy#)

_____

Policy Owner's Name_____
Relationship to Patient

_____

Policy Owner's Birth Date

_____

Social Security #

_____

Policy Owner's Employer_____

7. Secondary Dental Insurance

Insurance Company Name

_____

Insurance Company Address

_____

Insurance Company
Phone#_____

Group # (Plan, Local, or Policy#)

_____

Policy Owner's Name_____
Relationship to Patient

_____

Policy Owner's Birth Date

_____

Social Security #

_____

Policy Owner's Employer_____

How did you hear about our office? Or who may we thank for the referral?

_____

PATIENT MEDICAL HISTORY

Patient's Name_____Birth Date_____

	YES	NO		YES	NO
Heart Murmur	□	□	Asthma	□	□
Heart Disease	□	□	Lung Disease	□	□
Cardiac, Pacemaker	□	□	Tuberculosis	□	□
High Blood Pressure	□	□	Epilepsy	□	□
Rheumatic Fever	□	□	Nervous Disorder	□	□
Prolonged Bleeding When Cut	□	□	Chemical Dependency	□	□
Blood Transfusion, Date_____	□	□	HIV/AIDS	□	□
Cancer, Tumor	□	□	Metallic Implant	□	□
Kidney Disease	□	□	Glaucoma	□	□
Diabetes	□	□	Is the patient pregnant?	□	□
Hepatitis, Liver Disease	□	□	Bleeding Gums	□	□
Thyroid Disease	□	□	Bad Breath	□	□
Cold Sore, Fever Blister	□	□	Puberty/Growth Spurt	□	□
Drug/Food Allergy	□	□	Latex Allergy	□	□

Patient's Name_____Birth Date_____

Any allergy to Medications/Food(s):

_____

_____

Is there any other health information that should be known?

_____

_____

_____

Is the patient taking any medications? □ Yes □ No If yes, please list the medications and reasons:

_____

_____

Has the patient recently been under the care of a physician or had a serious illness or operation in the last 5 years?
□ Yes □ No If Yes, please explain

_____

_____

_____

Name & Phone Number of the patient's Physician:

_____

_____

Is this your child's first dental visit? □ Yes □ No

Last Dental Visit: _____ Dentist's Name & Phone Number:

_____

Does the patient have a specific dental problem that needs attention? □ Yes □ No
If yes, please explain:

_____

_____

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

_____ _____ _____

Signature of Parent/Guardian **Date** **Relationship to Patient**