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PATIENT REGISTRATION AND HEALTH HISTORY

Date ________________ M____ F____
Child's Name ________________ "Nickname" ________________
Address ________________ City ________________ Zip ________
Date of Birth ________________ Home Phone ________________
Number of brothers and sisters (OLDER) ________________ Younger ________
Favorite Activities, TV shows, etc. ________________
Name of Person Financially responsible for the account ________________
Whom may we thank for referring you to our office? ________________
Is another member of your family or relative a patient at our office? _____ Name? ________________

Date of Birth:
Father's Name ________________
Soc. Sec. # ________________
Address if different from child's ________________
Street ________________
City ________________ Zip ________
Phone ________________ Cell ________________
E-Mail ________________
Employer ________________
Bus. Address ________________
Work Phone ________________ Ext. ________

Date of Birth:
Mother's Name ________________
Soc. Sec. # ________________
Address if different from child's ________________
Street ________________
City ________________ Zip ________
Phone ________________ Cell ________________
E-Mail ________________
Employer ________________
Bus. Address ________________
Work Phone ________________ Ext. ________

INSURANCE INFORMATION

Insured's Name ________________ Insured's Soc. Sec. # ________________
Insurance Co. ________________ Group # ________________ Local # ________________
Insurance Co. Address ________________
Do you have dual coverage? _____ Yes _____ No if yes:
Insured's Name ________________ Insured's Soc. Sec. # ________________
Insurance Co. ________________ Group # ________________ Local # ________________
Insurance Co. Address ________________
Insured's Employer ________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ________________
Complete Address ________________
Phone ________________ Cell ________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ________________

DENTAL HISTORY

Reason for visit. (Check-up, Toothache, Etc.) ______

Is this the 1st dental visit for this child? (To any dentist) ______ If yes, please skip to next box.

How long ago was last visit? ______

Were previous visits pleasant or unpleasant ______

Did He/ She object to anything in particular? ______

Has your child ever sustained any injuries to the face or teeth? ______ If yes, please describe ______

Has your child any history of any of the following? Thumb or Finger Sucking ______ Pacifier Sucking ______

Tongue Thrust ______ Mouth Breathing ______ If bottle fed, age bottle discontinued ______

Home water supply if from (check one) ______ Public Water Supply ______ Well ______

Does your child take a Flouride Suppliment? ______ Use a Flouride Rinse? ______

MEDICAL HISTORY

Name of Family Physician or Pediatrician ______ City ______

Is your child in good helath ______ Does He/she take any medication? ______

Has your child ever had any serious illnesses or operations? ______

Has your child ever been admitted to a hospital? ______

Does your child have any allergies to medication? ______ Other allergies? ______

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

Rheumatic Fever ______ Asthma ______ Anemia ______

Heart Disease ______ Kidney Disease ______ Seizures ______

Heart Murmur ______ Liver Disease ______ Other (Please Explain) ______

Diabetes ______ Bleeding Problem ______

Does your child have a handicap or perpetual problem? If yes, please explain ______

FOR FEMALE PATIENTS ONLY:

Are you pregnant? Yes ☐ No ☐ If yes, what month? ______ Are you taking birth control pills? Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficent manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any diagnostic aids appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy that may indicate in connection with (Name of Patient) ______ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsiblity for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. Balances not paid within 60 days will incur 1 1/2% per month (18% annual) interest charge. I further understand that in the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Signature ______ Date ______