PATIENT REGISTRATION

Patient Information

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

Nickname: _____ E-mail Address:_____

Mailing Address:_____ Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Birth Date:_____ Age:_____ Social Security #:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment status: ☐Not Employed ☐Full Time ☐Part Time ☐Retired Name of Employer: _____

Student Status: ☐ Full Time ☐ Part Time Name of School if Student:_____

Previous Dentist Name:_____ Date of Last Visit:_____

Preferred Pharmacy Name and Location:_____

Parent or Legal Guardian (if patient is minor)

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

Mailing Address:_____ Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Birth Date:_____ Social Security #:_____ Relationship to patient:_____

Primary and Secondary Insurance Information

Name of Primary Insured:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #:_____ Insured Birth Date:_____

Employer:_____ Insured ID#_____

Name of Secondary Insured:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security #_____ Insured Birth Date:_____

Employer:_____ Insured ID#_____

Please provide a copy of the insurance card

CHILD HEALTH/DENTAL HISTORY FORM

Has the child had any history of, or conditions related to, any of the following:

☐Anemia	☐Cancer	☐Epilepsy	☐HIV +/AIDS	☐Mononucleosis	☐Thyroid
☐Arthritis	☐Cerebral Palsey	☐Fainting	☐Immunizations	☐Mumps	☐Tobacco/Drug Use
☐Asthma	☐Chicken Pox	☐Growth Problems	☐Kidney Problems	☐Pregnancy (teens)	☐Tuberculosis
☐Bladder	☐Chronic Sinusitis	☐Hearing Problems	☐Latex Allery	☐Rheumatic Fever	☐Venereal Disease
☐Bleeding disorder	☐Diabetes	☐Heart Problems	☐Liver Problems	☐Seizures	☐Other _____
☐Bones/joints	☐Ear Aches	☐Hepatitis	☐Measles	☐Sickle Cell	

Please list the name and phone number of the child's physician:

NAME OF PHYSICIAN: _____PHONE: _____

Patient's Name: _____ Date: _____

CHILD'S HISTORY

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? …☐Yes ☐No
If yes, please list: _____
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? ……☐Yes ☐No
If yes, please explain: _____
Is the child allergic to anything else, such as certain foods? ……☐Yes ☐No
If yes, please explain: _____
Has the child ever had a serious illness? ……☐Yes ☐No
If yes, when? _____Please describe: _____
Has the child ever been hospitalizied? ……☐Yes☐No
If yes, when? _____Please describe: _____
Does the child have a history of any other illnesses? ……☐Yes ☐No
If yes, please list: _____
Has the child ever received a general anesthetic? ……☐Yes ☐No
Does the child have any speech difficulties? ……☐Yes ☐No
Has the child ever had a blood transfusion? ……☐Yes ☐No
Is the child physically, mentally, or emotionally impaired? ……☐Yes ☐No
Does the child experience excessive bleeding when cut? ……☐Yes ☐No
Is the child currently being treated for any illnesses? ……☐Yes ☐No
If yes, please explain: _____
Is this the child's first visit to a dentist? ……☐Yes ☐No
If no, what was the date of the last dentist visit? Date: _____

CHILD'S HEALTH HISTORY FORM (continued)

Patient's Name: _____ Date: _____

Has the child had any problem with dental treatment in the past? ……☐Yes ☐No
If yes, please explain: _____
Has the child ever had dental radiographs (x-rays)? ……☐Yes ☐No
Has the child ever suffered any injuries to the mouth, teeth or head? ……☐Yes ☐No
Has the child had any problems with the eruption (losing) or shedding of teeth? ……☐Yes ☐No
Has the child had any orthodontic (braces) treatment? ……☐Yes ☐No
Does the child suck his/her thumb, fingers or pacifier? ……☐Yes ☐No
What is your child's favorite thing to drink? List: _____
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____
At what age did the child stop bottle feeding? Age_____ Breast feeding? Age_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____