PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ M.I. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ SEX: _____ FEMALE _____ MALE DOB: _____

AGE: _____ PREFERRED NAME: _____ E-MAIL: _____

Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY FIRST NAME:

FIRST NAME: _____ LAST NAME: _____ M.I. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

RELATIONSHIP TO INSURED: _____ BIRTH DATE: _____ SOCIAL SECURITY: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED IF DIVORCED, CHILD RESIDES WITH: _____

WHO HAS CUSTODY: _____ DO PARENTS AND CHILD LIVE TOGETHER: _____

IF NO, WHO HAS RESPONSIBILITY FOR MAKING DECISIONS ABOUT MEDICAL/DENTAL CARE: _____

PLEASE NOTE THAT THE PARENT WHO EXECUTES THIS DOCUMENT AND AUTHORIZES TREATMENT WILL BE CONSIDERED THE RESPONSIBLE PARTY FOR THIS CHILD'S FINANCIAL ACCOUNT

PRIMARY INSURANCE INFORMATION:

NAME OF POLICY HOLDER: _____ HOLDER'S SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

ADDRESS: _____ ADDRESS: _____

CITY, STATE, ZIP CODE: _____ CITY, STATE, ZIP CODE: _____

SECONDARY INSURANCE INFORMATION:

NAME OF POLICY HOLDER: _____ HOLDER'S SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

ADDRESS: _____ ADDRESS: _____

CITY, STATE, ZIP CODE: _____ CITY, STATE, ZIP CODE: _____

CONSENT: The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents poses a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier. I also assign all dental insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if requested. I understand that where appropriate, credit reports may be obtained.

PATIENT SIGNATURE (Parent of Child) _____ DATE: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Pediatrician's Name, Address, and Phone Number_____

_____.

Are you under a physician's care now?	◯ Yes ◯ No	If yes, please explain:	_____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain:	_____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain:	_____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, please explain:	_____
Are you on a special diet?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No		

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Local Anesthetics ◯ Metal ◯ Latex ◯ Sulfa Drugs

◯ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

ADHD/ADD	Yes	No	Cortisone Medicine	Yes	No	Herpes	Yes	No	Sickle Cell Disease	Yes	No
AIDS/HIV Positive	Yes	No	Depression	Yes	No	High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	High Cholesterol	Yes	No	Spina Bifida	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hives or Rash	Yes	No	Stomach/Intestinal Disease	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Hypoglycemia	Yes	No	Stroke	Yes	No
Angina	Yes	No	Emphysema	Yes	No	Irregular Heartbeat	Yes	No	Swelling of Limbs	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Kidney Problems	Yes	No	Thyroid Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Leukemia	Yes	No	Tonsillitis	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Asperger's Syndrome	Yes	No	Fainting Spells/Dizziness	Yes	No	Low Blood Pressure	Yes	No	Tumors or Growths	Yes	No
Asthma	Yes	No	Frequent Cough	Yes	No	Lung Disease	Yes	No	Ulcers	Yes	No
Autism	Yes	No	Frequent Diarrhea	Yes	No	Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No
Behavior Issues	Yes	No	Frequent Headaches	Yes	No	Osteoporosis	Yes	No	Yellow Jaundice	Yes	No
Blood Disease	Yes	No	Genital Herpes	Yes	No	Pain in Jaw Joints	Yes	No			
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Parathyroid Disease	Yes	No			
Breathing Problem	Yes	No	Hay Fever	Yes	No	Psychiatric Care	Yes	No			
Bruise Easily	Yes	No	Heart Attack/Failure	Yes	No	Radiation Treatments	Yes	No			
Cancer	Yes	No	Heart Murmur	Yes	No	Recent Weight Loss	Yes	No			
Chemotherapy	Yes	No	Heart Pacemaker	Yes	No	Renal Dialysis	Yes	No			
Chest Pains	Yes	No	Heart Trouble/Disease	Yes	No	Rheumatic Fever	Yes	No			
Cold Sores/Fever Blisters	Yes	No	Hemophilia	Yes	No	Rheumatism	Yes	No			
Congenital Heart Disorder	Yes	No	Hepatitis A	Yes	No	Scarlet Fever	Yes	No			
Convulsions	Yes	No	Hepatitis B or C	Yes	No	Shingles	Yes	No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:_____

_____

_____

Comments: _____

_____

_____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____