

PATIENT NAME _____ Male Female
Last First M.I. Date of Birth Circle One

MOTHER'S NAME _____
Last First M.I.

ADDRESS _____
CITY ZIP

EMPLOYER _____

POSITION _____

HOME PHONE _____

DAY CONTACT # _____

CELL/PAGER _____
SOCIAL SECURITY# _____ DATE OF BIRTH _____

FATHER'S NAME _____
Last First M.I.

ADDRESS _____

EMPLOYER _____

POSITION _____

HOME PHONE _____

DAYCONTACT# _____

CELL/PAGER _____
SOCIAL SECURITY# _____ DATE OF BIRTH _____

REFERRED BY? _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

RELATIONSHIP TELEPHONE

INSURANCE: _____

PATIENT SPECIAL INTERESTS, SPORTS OR HOBBIES _____

FOR OFFICE USE _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care and authorize office staff to review information in my child's chart as needed. I authorize you to take and post pictures of my child within the office.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for dental benefits, and to call or mail notification to me regarding my child's treatment.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
I have been shown a copy of this office's Notice Of Privacy Practices and I attest to the accuracy of the information on this page.

PARENT'S OR GUARDIAN'S SIGNATURE _____ RELATIONSHIP _____ DATE _____

REGISTRATION

PATIENT'S NAME _____ Last First M.I. Nickname

PARENT/GUARDIAN NAME _____ RELATIONSHIP _____

| DENTAL HISTORY-MARK THE APPROPRIATE ANSWER | YES NO | COMMENTS |
|---|--------|----------|
| 1. Is this your child's first visit to a dentist?..... | Y N | |
| 2. If not, when was the last visit _____ | | |
| 3. Have any dental x-rays ever been taken?..... | Y N | |
| 4. How does your child receive Fluoride? (circle appropriate answers) Water (Military bases only), Fluoride drops or tablets, Fluoride rinse or gel, Fluoride toothpaste. | | |
| 5. Has your child had any problem with dental treatment in the past?..... | Y N | |
| 6. Do you or your child think there is anything wrong with his/her teeth? _____ | Y N | |
| 7. Who brushes your child's teeth? (circle appropriate answer) Child brushes his/her own teeth Mother Father Other _____ | | |
| 8. Who flosses your child's teeth? (circle appropriate answer) Child flosses his/her own teeth Mother Father Other _____ | | |
| MEDICAL HISTORY | | |
| 1. Does your child have a health problem?..... | Y N | |
| 2. Is your child under the care of a physician?..... | Y N | |
| 3. Physician's name _____ | | |
| 4. Physician's telephone number _____ | | |
| 5. Is your child receiving any medication?..... | Y N | |
| What? _____ | | |
| 6. Is your child allergic to Penicillin, antibiotics or other drugs?..... | Y N | |
| 7. Does your child have other allergies?..... | Y N | |
| 8. Has your child had any serious illness?..... | Y N | |
| What? _____ | | |
| When? _____ | | |
| 9. Has your child ever had surgery?..... | Y N | |
| 10. Does your child have a heart murmur?..... | Y N | |
| 11. Does your child experience severe or prolonged bleeding?..... | Y N | |
| 12. Does your child have AIDS or has he/she tested HIV positive?..... | Y N | |
| 13. Does your child have asthma?..... | Y N | |
| 14. Is your child subject to nervous disorders? If yes circle conditions child has: Fainting? Seizures? Behavioral/Learning problems? | | |
| 15. Has your child had a history of: (circle appropriate responses) diabetes, heart trouble, hepatitis, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, developmentally delayed, eyesight problems, cancer, speech impairments, hearing loss. | | |
| 16. Purpose of dental visit? _____ | | |

I know there were a lot of questions but you're finally done!

I CERTIFY THAT THE ABOVE IS COMPLETE AND ACCURATE:

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

WEIGHT

CHILD DENTAL/MEDICAL HISTORY

MED. ALERT