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PATIENT REGISTRATION FORM

TELL US ABOUT YOUR CHILD

Child's name__________ Nickname__________ ☐Male ☐Female

Child's birthdate__________ Child's age_____ School__________ Grade_____

Child's home address__________ City__________ State_____ Zip_____

Child's home number__________ Social Security #__________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name__________ Relation__________ Do you have legal custody of the child? ☐Yes ☐No

Emergency Contact "not living at same address" (name & telephone) __________

Whom may we thank for this referral?__________

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information	**Father's Information**
Name __________ Date of birth _____	Name __________ Date of birth _____
Address __________ For how long?_____	Address __________ For how long?_____
__________	__________
Employed by __________ For how long?_____	Employed by __________ For how long?_____
Occupation __________	Occupation __________
SS# __________	SS# __________
Driver's license # __________	Driver's license # __________
Business phone __________	Business phone __________
Home phone __________	Home phone __________
Cell phone__________	Cell phone__________

DENTAL INSURANCE COMPANY

Only primary insurance will be filed

Insurance Co. name __________

Insurance Co. address __________

Insurance Co. phone __________ Group # (plan, local, or policy #)__________

Insured's name __________ Relationship to child __________

Insured's birthdate__________ ID # __________ Insured's employer__________

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Johnson, otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

____

Signature **Date**

Name:______________________________ Date:______________

COMMENTS *(For office use only)* | **Med. Alert**

MEDICAL HISTORY

1. Name of Pediatrician ______________________________
2. Is your child under care of a specialist?______________ ☐ Yes ☐ No
   If yes, since when and why/______________________________
3. Is your child receiving any medication?______________ ☐ Yes ☐ No
   List current medications ______________________________
4. Is your child allergic to any drugs, such as penicillin?______________ ☐ Yes ☐ No
5. Dose your child have other allergies? ______________ ☐ Yes ☐ No
6. Has your child had any serious illness? ______________ ☐ Yes ☐ No
7. Has your child ever been hospitalized or had surgery? ______________ ☐ Yes ☐ No
8. Has your child had a history of any of the following? **Please check a response for each question and circle all that apply:**
   - Heart trouble, murmur, or heart surgery ______________ ☐ Yes ☐ No
   - Rheumatic fever or scarlet fever ______________ ☐ Yes ☐ No
   - Asthma, TB, or lung problems ______________ ☐ Yes ☐ No
   - HIV infection or AIDS ______________ ☐ Yes ☐ No
   - Hemophilia or bleeding problems ______________ ☐ Yes ☐ No
   - Sickle cell anemia/blood disorder ______________ ☐ Yes ☐ No
   - Hepatitis or liver problems ______________ ☐ Yes ☐ No
   - Kidney infection ______________ ☐ Yes ☐ No
   - Diabetes______________ ☐ Yes ☐ No
   - Cancer, tumor, leukemia ______________ ☐ Yes ☐ No
   - Thyroid or other glandular problems______________ ☐ Yes ☐ No
   - Latex or rubber allergy ______________ ☐ Yes ☐ No
   - Epilepsy, seizures, fainting ______________ ☐ Yes ☐ No
   - Cerebral palsy______________ ☐ Yes ☐ No
   - Vision problems______________ ☐ Yes ☐ No
   - Development delays______________ ☐ Yes ☐ No
   - Speech or hearing problems ______________ ☐ Yes ☐ No
   - Emotional or psychological problems______________ ☐ Yes ☐ No
   - Congenital birth defects ______________ ☐ Yes ☐ No
   - Cleft lip or palate______________ ☐ Yes ☐ No
   - Malignant hyperthermia ______________ ☐ Yes ☐ No
   - Other medical condition ______________ ☐ Yes ☐ No
   - Is parent or patient pregnant? ______________ ☐ Yes ☐ No

PURPOSE OF TODAY'S VISIT ______________________________

DENTAL HISTORY

1. When and where was your child's last dental visit? ______________
2. What was the purpose of that visit? ______________
3. Were any x-rays taken at your child's last dental visit? ______________ ☐ Yes ☐ No
4. Did your child have difficulty cooperating? ____ ☐ Yes ☐ No
5. Was/is your child bottle fed? ______________ ☐ Yes ☐ No
6. Was/is your child breast fed?______________ ☐ Yes ☐ No
7. If your child has been weaned please indicate at what age: ______________
8. When does your child brush his/her teeth?
   - ☐ Upon arising
   - ☐ After eating any food
   - ☐ Right after meals
   - ☐ Before going to bed
9. Do you assist/supervise your child's brushing? __ ☐ Yes ☐ No
10. Does your child take fluoride supplements? _____ ☐ Yes ☐ No
11. Have any cavities been noted in the past?________ ☐ Yes ☐ No
12. Were any teeth (baby or permanent) removed by extraction? ______________ ☐ Yes ☐ No
13. Have there been any injuries to teeth, such as falls, blows, chips, etc.?______________ ☐ Yes ☐ No
14. Has anyone in the family, including parents, had orthodontics? ______________ ☐ Yes ☐ No
15. Has your child had a toothache recently? ________ ☐ Yes ☐ No
    If yes, explain:______________________________
    ____
16. Do you expect your child to be cooperative? ____ ☐ Yes ☐ No
17. Does your child have other siblings seen by us?__ ☐ Yes ☐ No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Johnson and his staff to perform such treatments, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Signature ______________________________ **Date**