PATIENT REGISTRATION

Patient Information

Account No. _____

Patient's Last Name		First Name	Middle Initial	Social Security #
Nickname	Sex	Birthdate (Mo., Day, Year)	Number of Brothers	Number of Sisters
Street Address		City, State, Zip Code		(Area Code) Home Phone

Father's Information

Father's Last Name	First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address *(If different than patient)*	City, State, Zip Code		(Area Code) Home Phone #
Father's Social Security #	Email		(Area Code) Cell Phone #
Employed By	Job Position	Business Address	(Area Code) Business Phone #
Father's Dental Insurance	Group #	Insurance ID#	

Mother's Information

Mother's Last Name	First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address *(If different than patient)*	City, State, Zip Code		(Area Code) Home Phone #
Mother's Social Security #	Email		(Area Code) Cell Phone #
Employed By	Job Position	Business Address	(Area Code) Business Phone #
Mother's Dental Insurance	Group #	Insurance ID#	

Step Parent, Guardian or Other Insurance Carrier

Last Name	First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address *(If different than patient)*	City, State, Zip Code		(Area Code) Home Phone #
Social Security #	Email		(Area Code) Cell Phone #
Employed By	Job Position	Business Address	(Area Code) Business Phone #
Dental Insurance	Group #	Insurance ID#	
Relationship to Patient			

OVER

Emergency Information

Person to be reached in case of emergency, other than parent:

Name	Relationship to Patient	(Area Code)Phone Number
Name	Relationship to Patient	(Area Code)Phone Number

Consent For Treatment Of A Minor

Because your child is a minor, signed permission is required from a parent or legal guardian before any dental services can be rendered. By signing your consent below, you are giving the Doctors permission to perform a dental examination including x-rays (periapical, bitewing, occlusal, panoramic, and/or cephalometric, radiographic films), photographs, and/or models. This authorization also includes all necessary treatment, medications and therapy indicated for the dental care of your child, including local anesthetic and nitrous oxide analgesia as indicated by the doctor. The doctors are also given my authorization to use their professional judgement in patient management regimes as they feel necessary.

I understand that, at any time, I have questions I may speak to the doctor treating my child. I understand I can ask questions until I have received satisfactory answers to those questions.

I authorize release of information to my insurance carrier. I authorize payment directly to the doctor from my insurance carrier.

I understand and agree that, (regardless of my insurance status), I am responsible for the balance on my account at the time professional services are rendered. I understand it is my responsibility to pay all fees not covered by my insurance. I understand it is my responsibility to pay all costs associated with collection of unpaid and overdue balances including the costs associated with collection agencies should such action be indicated. I have read all of the information and have completed this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes. I certify by signing this, I am the minor's legal parent or guardian.

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

DENTAL ASSISTANT _____

Medical History

Patient's Name_____ Date of Birth_____

Family Physician or Pediatrician_____ Office Phone Number_____

Family Dentist_____ Whom may we thank for referring you? _____

Does your child have any dental complaints?_____

General health of the patient? (please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Last complete physical?_____ Findings?_____

Is your child presently under the care of a physician? ☐ Yes ☐ No

Has your child had any serious operations, illnesses, injuries and/or hospitalizations? ☐ Yes ☐ No

If yes, please list dates and reasons_____

_____

Is your child taking any medication now? ☐ Yes ☐ No If yes, please list the names of the medication, dosage and purpose: _____

_____

Is your daughter taking any form of Contraceptive Medication (i.e., birth control pills) at this time? (Prescription of certain antibiotics may interfere with the effectiveness of the birth control medication.) ☐ Yes ☐ No Is your daughter pregnant? ☐ Yes ☐ No

Is your child allergic to:

☐ Yes	☐ No	Latex	☐ Yes	☐ No	Codeine
☐ Yes	☐ No.	Penicillin/Amoxicillin	☐ Yes	☐ No	Local anesthetics
☐ Yes	☐ No	Sulfa medications	☐ Yes	☐ No	Other?_____

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

☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Heart disease/disorders	☐ Yes	☐ No	Stomach/GI problems
☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	Cancer/tumors
☐ Yes	☐ No	Abnormal blood pressure	☐ Yes	☐ No	Chemotherapy/ radiation
☐ Yes	☐ No	Blood disorders/dyscrasias	☐ Yes	☐ No	Neurological disorders
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Recurrent headaches
☐ Yes	☐ No	Prolonged bleeding	☐ Yes	☐ No	Epilepsy/Seizures
☐ Yes	☐ No	Bruise easily	☐ Yes	☐ No	Skin disease/disorders
☐ Yes	☐ No	Blood transfusion	☐ Yes	☐ No	Bacterial/viral infections
☐ Yes	☐ No	Lung disease	☐ Yes	☐ No	STD's/ Herpes
☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	AIDS/HIV
☐ Yes	☐ No	Respiratory infections	☐ Yes	☐ No	Anorexia/Bulimia
☐ Yes	☐ No	Coughing	☐ Yes	☐ No	Congenital birth defects
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Cleft lip/Cleft palate ;
☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No	ADD/ADHD
☐ Yes	☐ No	Allergies	☐ Yes	☐ No	Autism
☐ Yes	☐ No	Kidney/bladder disease	☐ Yes	☐ No	Mental impairment
☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Developmental delays
☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Learning problems
☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Emotional problems
☐ Yes	☐ No	Pancreatic disease	☐ Yes	☐ No	Physical handicaps
☐ Yes	☐ No	Endocrine disorders	☐ Yes	☐ No	Vision problems
☐ Yes	☐ No	Thyroid disorder	☐ Yes	☐ No	Hearing problems

If **yes**, to any of the disorders listed any other disease, condition, or problem not listed please **explain fully** on back:

OVER

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PERSONAL HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____

Please print patient's name(s)

_____ _____

Please print your name | Please sign your name

_____ _____

Legal Representative | Description of Authority

Your comments regarding Acknowledgements or Consents: _____

Your email address: _____

FOR PARENT USE