PATIENT REGISTRATION

PATIENT INFORMATION

Full Name_____

Address_____City_____State_____Zip_____

Birth Date_____Age_____Sex _____M _____F

RESPONSIBLE PARTY INFORMATION

Full Name_____Relationship to Patient_____

Address (if same as above, leave blank)_____City_____State_____Zip_____

Home Phone_____Cell Phone_____

Birth Date_____Sex _____M _____F Email Address_____

INSURANCE INFORMATION

Insured Full Name_____Relationship to Patient_____

Address (if same as above, leave blank)_____City_____

State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Birth Date_____

*Insurance Name_____ *Policy #_____*Group #_____

Medical Information

PHYSICIAN/PEDIATRICIAN INFORMATION

Pediatrician/Physician Name_____
Phone_____

MEDICAL NARRATIVE

1. Is your child:

Under the care of a doctor at the present time?	__No	__Yes, When?____ Why?_____
Taking any medications at the present time?	__No	__Yes, What?_____
Allergic to any medications?	__No	__Yes, What?_____
Allergic to any foods, materials or dyes?	__No	__Yes, What?_____

2. Has your child:

Had general anesthesia?	__No	__Yes
Had any complications with general anesthesia?	__No	__Yes, Explain_____
Had any surgeries?	__No	__Yes, When?_____ Why?_____
Ever been a patient at the Emergency Room?	__No	__Yes, When?_____ Why?_____
Ever been hospitalized as a patient?	__No	__Yes, When?_____ Why?_____

3. Does your child have, ever had or been diagnosed with any of the following: (please check all that apply)

___HIV+/AIDS	___Brain Surgery	___Heart problem/surgery	___Polio
___Anemia/Sickle cell trait	___Cancer-type: _____	___Hemophilia	___Pregnancy
___Allergy / Hay fever	___Chemotherapy/radiation	___Hepatitis A.B or C	___Rheumatic fever
___Arthritis / Rheumatism	___Cerebral Palsy	___High/low blood pressure	___Scarlet fever
___Artificial heart valve	___Chicken Pox	___Hormonal disturbance	___Scoliosis
___Artificial joint or limb	___Cleft Lip/palate	___Hydrocephalus	___Shunts
___Asthma	___Convulsions/seizures	___Kidney problems	__VA __ VV __ VP
___Attention Deficit Disorder	___Diabetes	___Leukemia	___Speech problems
___Autism	___Digestive disturbances	___Liver problems	___Surgeries
___Behavior/Learning Disabilities	___Earaches	___Malignant hyperthermia	___Syndrome:_____
___Problem learning?	___Emotional disturbances	___Measles	___Polio
___Problem concentrating	___Epilepsy	___Mental retardation	___Pregnancy
___Problem cooperating	___Eye problems	___Mumps	___Tetanus
___Problem understanding	___Fainting	___Mouth ulcers	___Tuberculosis
___Bleeding disorder	___Glandular disturbance	___Nutritional disturbances	___Venereal disease
___Birth defects	___Hearing loss/aids/implants	___Organ transplant	___Whooping cough
___Bone/Joint/Orthopedic problems	___Heart murmur	___Pneumonia	

4. Does your child have any other disease, condition or medical problem not mentioned above? __No __Yes, Please list_____

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

DENTAL INFORMATION

DENTAL INFORMATION

What is the reason for your child's first visit to our dental office? ___Consultation ___Emergency ___Preventative/Exam ___Other

Patient level of apprehension? ___High ___Medium ___Low ___None

Name of previous dentist_____Telephone_____

Has your child ever had an injury to the teeth, lips, tongue or chin in the past? ___Y ___N

DIETARY FACTS

Does your child eat between meals? ___Y ___N

Is your child a good eater? ___Y ___N

Does s/he eat a balanced diet? ___Y ___N

At what age was bottle/nursing stopped? ___Y ___N

Please list your child's favorite snacks:

FLUORIDE & TOOTH BRUSHING

Is your child taking fluoride supplements presently? ___Y ___N If Yes, what form? _____

Has your child received fluoride supplements in the past? ___Y ___N

Does your child drink? ___Bottle water ___well water ___Non-Filtered water ___Filtered city water

Does your child use fluoride toothpaste? ___Y ___N

Brushing frequency? ___1xdaily, am ___1xdaily, pm ___2xdaily ___After each meal/snack

What type of toothbrush does your child use? ___Regular ___Electric ___Cloth ___Other

Dental flossing frequency? ___Use daily ___Occasionally ___Never ___By parent ___By child

Who is responsible for tooth brushing? ___Parent ___Child ___Both

HABIT ASSESSMENT

Please check if any of the following habits exist or existed and answer all that apply:

Sucking History ___Still ___Past thumb/finger habit-stopped at ___yrs ___Never had thumb/finger habit

Was or is the habit done? ___Day & Night ___Night only ___When tired or sleepy

Grinding Teeth History ___Still ___Past grinding habit-stopped at ___yrs ___Never had grinding habit

Was or is the habit done? ___Day & Night ___Night only ___When tired or sleepy

Other Habits? ___Nail biting ___Lip biting ___Cheek and/or tongue biting ___Mouth breathing

Does your child snore? ___Y ___N

Is there any specific question / topic you would like to make sure we address while you and your child visit us?