CHILDREN'S DENTISTRY

PATIENT'S REGISTRATION AND HISTORY

IN ORDER TO PROVIDE THE BEST AND SAFEST COMPREHENSIVE DENTAL SERVICES FOR YOUR CHILD WE ARE THANKING YOU IN ADVANCE FOR FILLING OUT OUR DETAILED MEDICAL HISTORY FORM.

PLEASE PRINT

Date _____

Patient's Name _____ Nickname _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____

Age_____ Birth date _____ Female/Male_____

If patient is a minor, give parent's or guardian's name _____

How did you hear about our office? _____

Does the patient have or has he/she ever had any of the following conditions? _____

MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	Heart Murmur	☐	☐	Hepatitis/Liver Disease
☐	☐	Rheumatic Fever	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Heart Disease	☐	☐	Epilepsy
☐	☐	Thyroid Disease	☐	☐	Nervous Disorder
☐	☐	High Blood Pressure	☐	☐	Tumor, Cancer
☐	☐	Lung Disease	☐	☐	Cardiac Pacemaker
☐	☐	Metallic Implant, Shunts, Pins or Rods	☐	☐	Measles
☐	☐	Sore Throats	☐	☐	Tonsillitis
☐	☐	Tuberculosis	☐	☐	Ear aches
☐	☐	Chicken Pox	☐	☐	Glaucoma
☐	☐	Prolonged Bleeding When Cut	☐	☐	Mumps
☐	☐	Blood Transfusion	☐	☐	Bad Breath
☐	☐	Injury to Front Teeth	☐	☐	Stained Teeth
☐	☐	Bleeding Gums	☐	☐	Cold Sore, Fever Blister
☐	☐	**DRUG/FOOD ALLERGY**	☐	☐	Women: Are you Pregnant Now?
		If yes, to what medications/foods?	☐	☐	AIDS
		_____	☐	☐	Chemical Dependency
☐	☐	ADD /ADHD	☐	☐	Developmentally Delayed
		Attention Deficit Disorder/			Age level patient is at _____
		Attention Deficit Hyperactivity Disorder			

COMMENTS
(for Office Use Only)

Is the patient taking any medications?

If so, please list the medications: _____

Has the patient recently been under the care of a physician? **Y** ❑ **N** ❑ Reason: _____

Name of Medical Doctor for above reason: _____

Has the patient been hospitalized in the last 5 years? (if yes, please explain) _____

_____

Has the patient had a serious illness or operation? (if yes, please explain) _____

_____

Has the patient had difficulties in a dental office? (if yes, please explain) _____

_____

Is there any other health information that should be known? _____

_____

_____

Last dental care: Date _____ Name _____

Address _____

Has any member of your family received dental treatment in this office before? Names: _____

Names of other children in family _____

Name of family dentist _____

PEDIATRIC DENTISTRY SECTION

(To be filled out by parent or guardian)

Last well checkup _____

Name of pediatrician or primary care physician _____ Phone: _____

Are test and Immunizations (DPT, diphtheria, tetanus, whooping cough, measles and polio, vaccines) up to date?
Y ❑ N ❑

Has he/she had a skin test for tuberculosis? Yes ❑ No ❑

Is he/she doing well in school? Yes ❑ No ❑

Does he/she get along well with other children? Yes ❑ No ❑

Underline any of the following which your child has:

nail biting thumb sucking nightmares bad temper

irritable wets bed speech problems tongue thrust

Does your child have any limitations to physical activities?

Has your child had any history of being under oxygen or general anesthesia?

Does the child have a specific problem that needs attention? Yes ❑ No ❑

(Circle if applicable) Toothache Orthodontics Home Care Instructions

Child's pets and hobbies:

ORTHODONTIC SECTION

Is he/she a mouth breather? Yes ❑ No ❑ If so when ❑ while asleep ❑ while awake

Have you ever been informed of any missing or extra permanent teeth? Yes ❑ No ❑

Has he/she had any injuries to the face, mouth, or teeth?

Explain: _____

_____

Has he/she ever experienced any popping, clicking, pain or limitation of movement in the temporomandibular joint (TMJ)
Yes ❑ No ❑

Explain: _____

Does he/she experience headaches on a regular basis? Yes ❑ No ❑

Has an orthodontist been consulted previously? Yes ❑ No ❑

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

RESPONSIBLE PARTY INFORMATION

Resident Parent _____
Last First Middle Initial Marital Status

Address _____
Street City State Zip

How long at this address _____ Home Phone_____

E-mail Address:_____ Cell Phone_____

Previous Address(if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birth date _____ Relationship to patient _____

Employer_____ Occupation_____ Yrs. Employed_____

Employer's Address_____Work Phone _____

Other Parent _____
Last First Middle Initial

Address (if not the same) _____
Street City State Zip

Social Security # _____ Birth date _____ Relationship to patient _____

Home Phone _____ Work Phone_____

Employer_____ Occupation_____ Yrs. Employed_____

Employer's Address_____ Cell Phone_____

DENTAL INSURANCE INFORMATION

Primary Insured's Name _____Insured's Soc. Sec. # _____

Insurance Company _____ Group No._____Local No. _____

Insurance Co. Address _____ Insurance Phone # _____

Do you have dual coverage? ❑ Yes ❑ No

Secondary Insured's Name _____Insured's Soc. Sec. # _____

Insurance Company _____ Group No._____Local No. _____

Insurance Co. Address _____ Insurance Phone # _____

I give my consent for the Doctors of this office to do a complete/emergency oral and dental examination on the patient named previously. X-rays that are necessary to properly complete the exam may be taken. If a cleaning, fluoride treatment and oral hygiene instructions are to be included in the first examination, I will be informed. Any additional treatment received will be fully explained prior to starting treatment at each visit.

I agree to inform the doctors of any changes in medical or financial information.

I understand a credit report will be obtained from Credit Data SouthWest. Initials:_____

Requirement for Filing Insurance Claims: I authorize the release of any information relating to any dental claims and understand that I am personally responsible for all costs of dental treatment. I hereby authorize payment directly to to the dentist that performs services for treatment on my child.

By initializing this statement I accept financial responsibility for this child _____

Additional comments: _____

_____

_____
Signed (Parent or Guardian) Date