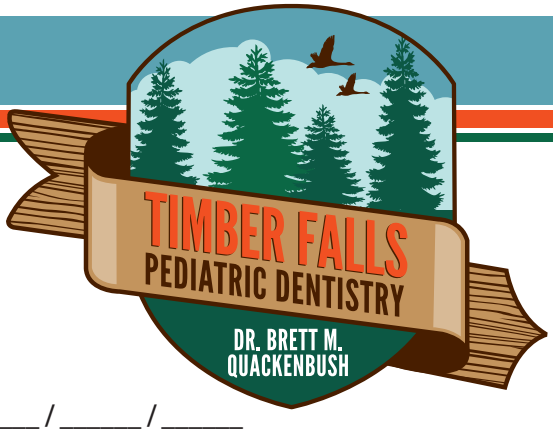

----PATIENT----
REGISTRATION

DATE: _____ / _____ / _____

PATIENT NAME: _____ BIRTH DATE: _____ / _____ / _____ AGE: _____

I LIKE TO BE CALLED:_____ SEX: (M) (F) PHONE # : _____

EMAIL: _____

HOME ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP: _____

(Y) (N) DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? (Y) (N) IS YOUR CHILD ADOPTED?

(Y) (N) DO WE SEE OTHER FAMILY MEMBERS? _____

---- PARENT / GUARDIAN INFORMATION ----

MOTHER'S NAME:_____ FATHER'S NAME _____

SOCIAL SECURITY # ___ ___ ___ - ___ ___ -___ ___ ___ ___ SOCIAL SECURITY # ___ ___ ___ - ___ ___ -___ ___ ___ ___

EMAIL: _____ EMAIL: _____

D.O.B. ___/___/___ CELL PHONE: _____ D.O.B. ___/___/___ CELL PHONE: _____

OCCUPATION: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER: _____

WORK PHONE: _____ WORK PHONE: _____

MARITAL STATUS: _____MARRIED _____DIVORCED _____SINGLE

---- DENTAL INSURANCE ----

PRIMARY INSURANCE

INSURED'S NAME:_____

SOCIAL SECURITY # ___ ___ ___ - ___ ___ -___ ___ ___ ___

DATE OF BIRTH: _____ / _____ / _____

INSURED'S EMPLOYER: _____

GROUP NUMBER (PLAN OR POLICY #) _____

INSURANCE COMPANY: _____

PHONE #: _____

ADDRESS: _____

SECONDARY INSURANCE

INSURED'S NAME:_____

SOCIAL SECURITY # ___ ___ ___ - ___ ___ -___ ___ ___ ___

DATE OF BIRTH: _____ / _____ / _____

INSURED'S EMPLOYER: _____

GROUP NUMBER (PLAN OR POLICY #) _____

INSURANCE COMPANY: _____

PHONE #: _____

ADDRESS: _____

--- REFERRAL INFORMATION ----

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PATIENT'S NAME_____D.O.B._____

----DENTAL HISTORY----

Previous dentist (if any) _____ Date of last dental exam ____ / ____ / ____

Does your child have dental pain? (Y) (N) Level of pain (1-10) _____

Has your child had a negative dental experience in the past? (Y) (N)

If yes, please explain:_____

Has your child received fluoride supplements? (Y) (N) If yes, what kind? _____

---- MEDICAL HISTORY ----

CHILD'S PHYSICIAN _____ PHONE # _____ LAST VISIT: ___/___/___

Is your child currently taking any medications? ❍ YES ❍ NO

If so, please list:_____

Does your child have any known allergies (medication, food, latex, seasonal)? ❍ YES ❍ NO

If so, please list_____

Are your child's immunizations current? ❍ YES ❍ NO

Any injuries to your child's mouth or jaw? ❍ YES ❍ NO (if yes please explain)

_____

PLEASE ANSWER THE FOLLOWING. Has your child ever had a history of:

Y	N	
❍	❍	ADHD/ADD
❍	❍	AIDS/HIV
❍	❍	Allergies: Type_____
❍	❍	Anemia
❍	❍	Asthma
❍	❍	Autism
❍	❍	Blood disorder/bleeding problems
❍	❍	Brain or head injury
❍	❍	Cancer, tumor or leukemia
❍	❍	Cerebral palsy
❍	❍	Cleft lip/palate
❍	❍	Communication Disorder/Developmental Delay

Y	N	
❍	❍	Diabetes
❍	❍	Epilepsy/Seizures
❍	❍	Hearing/sight Impaired
❍	❍	Heart Condition Type_____
		- Need premed. ❍ YES ❍ NO
❍	❍	Hemophilia Type_____
❍	❍	Hepatitis Type _____
❍	❍	Respiratory Problems
❍	❍	Rheumatic Fever
❍	❍	Syndrome: Type _____
❍	❍	Tonsillitis
❍	❍	Tuberculosis
❍	❍	Other_____

Is there any other information we should know about your child's medical history?

_____

Our office is committed to meeting or exceeding the standards of infection control as mandated by OSHA, the CDC and the ADA.

I acknowledge the information that I have given is complete and correct to best of my knowledge, it will be held in my strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I give my consent to this office's use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations. I have received a copy of Timber Falls Privacy Practices. I authorize insurance benefits to be paid directly to the doctor. Even though I may have dental insurance coverage, I understand payment for services rendered is my responsibility and payment is due at time if service. I further agree to pay all finance charges, collection costs, attorney fees and all other costs that may incur to enforce collection of any amounts outstanding.

SIGNATURE _____ RELATION _____ DATE: _____/_____/_____