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pediatric & adolescent registration form

Date ____________________

Patient Information

Last Name ____________________ First Name ____________________ Middle Initial ________ Sex ________

Prefers to be Addressed By ____________________ Date of Birth ____/____/____ Age (years) ________

Address ____________________ Apt. # ________

City ____________ State ________ Zip ________ Home Telephone ____________

Other family members treated at this office ____________________

Parental Information

Circle One: Mother, Stepmother, Guardian

Name ____________________

Date of Birth ____/____/____

Social Security #____________

E-mail Address ____________________

Cell Phone ____________________

Does Patient Live With You? ____________

Employer ____________________

Employer Address ____________________

Work Phone ____________________

Complete if DIFFERENT from patient's home information:

Home Address ____________________

City ____________ State ______ Zip ______

Home Telephone ____________

Circle One: Father, Stepfather, Guardian

Name ____________________

Date of Birth ____/____/____

Social Security #____________

E-mail Address ____________________

Cell Phone ____________________

Does Patient Live With You? ____________

Employer ____________________

Employer Address ____________________

Work Phone ____________________

Complete if DIFFERENT from patient's home information:

Home Address ____________________

City ____________ State ______ Zip ______

Home Telephone ____________

Dental Insurance Information

(Please provide your insurance card to the receptionist)

Primary Insurance

Company____________________

Address ____________________

City ____________ State ______ Zip ______

Insurance Telephone ____________________

ID#____________________

Policy Holder's Name ____________________

Relationship to Patient ____________________

Secondary Insurance

Company____________________

Address ____________________

City ____________ State ______ Zip ______

Insurance Telephone ____________________

ID#____________________

Policy Holder's Name ____________________

Relationship to Patient ____________________

Referral Information

How did you hear about us? ☐ Dentist ☐ Family ☐ Friend ☐ Pediatrician ☐ School Presentation ☐ Web Site ☐ Yellow Pages ☐ Other

Name of person to thank for referral ____________________

DENTAL HISTORY

1. Previous dentist (if any) ______ Date of last dental exam ______
2. When, if ever, were x-rays taken? ______
3. Has your child had any unfavorable dental experiences? ______
4. Has your child been treated with Nitrous Oxide (laughing gas) ______ Lidocaine (local anesthetic) ______
5. Mouth habits (Please check): ☐ Thumb sucking ☐ Pacifier ☐ Mouth breathing ☐ Finger habit ☐ Tooth grinding ☐ Other ______
6. Has your child had teeth removed? ______
7. How often does your child brush? ______ Floss? ______
8. Is there parental supervision? ______ Brushing? ______ Flossing? ______
9. Does your child drink fluoridated water? ______
10. Does your child use any fluoride supplements (rinses, vitamins)? ______
11. Is your child still nursing? ______ taking a bottle? ______
12. Does your child have a specific dental problem that need to be addressed? ______
13. Has your child had trauma to the mouth/teeth?

    If so, explain ______

MEDICAL HISTORY

1. Is your child's general health good at this time? ☐ Yes ☐ No
2. Name of physician? ______ Date of last physical: ______
3. Is your child under the care of a physician at this time? ☐ Yes ☐ No

    Explain: ______
4. Is your child taking any medication? ☐ Yes ☐ No If yes, what: ______
5. Is your child allergic to any medication? (Penicillin, Sulfa, etc.) ☐ Yes ☐ No

    If yes, what: ______
6. Does your child have any other allergies (metals, seasonal, etc.) ☐ Yes ☐ No

    If yes, what: ______
7. Has your child had tonsils and adenoids removed? ☐ Yes ☐ No Date: ______
8. Has your child ever had a serious illness or been hospitalized? ☐ Yes ☐ No Date: ______

    Explain: ______
9. Has your child ever been advised by their physician to take an antibiotic prior to any dental treatments? ☐ Yes ☐ No

    If yes, antibiotic name and method: ______

Please check all conditions your child has now or has had previously

______Heart condition, if yes, specify ______
______Hepatitis (type______)
______Birth defect
______Diabetes
______Tuberculosis
______Blood disorders/bleeding problems
______Sickle cell
______Asthma
______Epilepsy (seizures)
______Kidney problems
______Liver disease
______AIDS or H.I.V. positive
______Prosthetic (artificial) joint
______Radiation therapy (cancer)
______Autistic
______Mentally handicapped
______ADD/ADHD
______Emotional anxiety
______Sinusitis
______Headaches/migraines
______Cleft palate/lip
______Spina bifida
______Scoliosis
______Latex allergy
______Other ______

I certify that the information given is correct and give consent to treat my child.

Signature: ______ Date ______

(Please Circle One) *PARENT* *GUARDIAN* *OTHER*

Reviewed by ______ Date ______