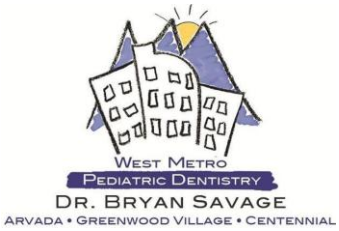

Patient Registration and Dental/Medical History Form

Patient Information

Child's Full Name _____ Nickname _____Birth Date: _____ Sex: ___M___F
Child Lives with ___Both Parents ___ Mother ___ Father ___ Other: _____
Siblings (Names and Ages) _____
Childs Favorite Sport/Activity/Hobby _____ School Name _____

Parent/Legal Guardian #1 Information

____Mother ____Father ____Stepmother ____Stepfather ____Grandmother ____Grandfather ___Other: _____
Full Name (First) _____ (Middle) _____ (Last) _____Nickname _____
Street Address _____City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Best? _____
Email Address _____ Social Security Number_____ Birth Date _____
Place of Employment _____ Occupation _____

Parent/Legal Guardian #2 Information

____Mother ____Father ____Stepmother ____Stepfather ____Grandmother ____Grandfather ___Other: _____
Full Name (First) _____ (Middle) _____ (Last) _____Nickname _____
____Street Address same as Legal Guardian #1 (above)
Street Address _____City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____ Best? _____
Email Address _____ Social Security Number_____ Birth Date _____
Place of Employment _____ Occupation _____

Emergency Contact Information (Person other than legal guardians above)

Full Name _____Relationship _____
Street Address _____City _____ State ___ Zip _____
Home Phone_____ Cell Phone_____ Work Phone_____ Best? _____

Primary Dental Insurance Information

Subscriber _____ Subscriber ID Number _____ Group Number _____
Insurance Company Name _____ Insurance Company State_____ Phone Number_____

Secondary Dental Insurance Information

Subscriber _____ Subscriber ID Number _____ Group Number _____
Insurance Company Name _____ Insurance Company State_____ Phone Number_____

How did you hear about us?

___Pediatrician: _____ _____ ___Dentist: _____ ___Orthodontist: _____
___School Visit: _____ ___Internet: _____ ___ Patient Family: _____
___Sibling is a patient here ___Walk by/ Drive by ___Other: _____

Appointment Policy

Your child's scheduled appointments are reserved specifically for your child. Any late arrivals or missed appointments affect many patients including your own child. It may be several weeks before we able to reschedule the appointment.

- If a cancellation is unavoidable, please call our office at least 24 hours in advance so that we may give your child's appointment time to another patient. If a cancellation is made with less than 24 hours notice this may be considered a missed/failed appointment.
- If you fail to arrive for your child's scheduled appointment without notice, this may be considered a missed/failed appointment.
- Please arrive at least 5 minutes early for your child's appointment. If you arrive late for your child's appointment, it may need to be canceled due to scheduling restrictions. This appointment may be considered a missed/failed appointment.
- All patients must be accompanied by a parent or legal guardian. If you are unable to accompany your child and do not provide written notification of another person's authorization to make medical decisions, we may need to cancel/reschedule your appointment. This may be considered a missed/failed appointment.
- Three missed/failed appointments may result in the termination of our dentist-patient relationship.

Dental History

Purpose of this appointment: _____ Problems/Concerns: _____
Date of Last visit _____ Previous Dentist _____ Family Dentist _____
Has your child complained of any dental pain? ___Yes ___No Explain:_____
Has your child had any unhappy dental experiences? ___Yes ___No Explain:_____
Has your child had any injuries to his/her mouth/teeth/head? ___Yes ___No Explain:_____
Does your child thumb/fingersuck, nailbite, mouthbreath, or snore? ___Yes ___No Explain:_____
Does your child nurse/use a bottle/sippy cup/pacifier? ___Yes ___No Explain:_____
Does your child have any unusual speech habits? ___Yes ___No Explain:_____
Does your child have any jaw issues (clicking/popping/pain)? ___Yes ___No Explain:_____
Does your child wear any orthodontic appliances? In the past? ___Yes ___No Explain:_____

Dental Hygiene/Dietary History

Do you assist your child with tooth brushing? ___Yes ___No
Does your child use fluoridated toothpastes? ___Yes ___No
Do you assist your child with flossing? ___Yes ___No
Does your child drink fluoridated water? ___Yes ___No
Does your child eat snacks between meals? ___Yes ___No
What is your child's favorite meal? _____
How many times per day does your child brush? _____
Does your child use a manual or an electric brush? _____
How many times per week does your child floss? _____
Does your child take fluoride supplements? ___Yes ___No Type: _____
Does your child drink between meals (except water)? ___Yes ___No
What is your child's favorite snack? _____

Medical History

Pediatric Office Name _____ Doctor's Name _____ Date Last Visit _____
Street Address _____ City _____State ___ Zip _____ Phone:_____
Is your child currently under a doctor's care for a specific reason? ___Yes ___No Explain: _____
_____
Is your child currently taking any medications? ___Yes ___No Explain: _____
_____

Does your child have any emotional/mental conditions we should be aware of? ___Yes ___No Explain: _____
_____
Does your child have any physical conditions we should be aware of? ___Yes ___No Explain: _____
_____
Does your child have any medical conditions we should be aware of? ___Yes ___No Explain: _____
_____

Is your child allergic to any medications? ___Yes ___No Explain: _____
Does your child have any other allergies (food/animals/latex/etc)? ___Yes ___No Explain: _____

Has your child ever been hospitalized? ___Yes ___No Explain: _____
Has your child had any surgeries? ___Yes ____No Explain: _____

Does your child require pre-medication before dental treatment? ___Yes ___No Explain:_____

Has your child ever been diagnosed with any of the following? ___Yes (See Below) ___No

__AIDS/HIV	__Anemia	__Arthritis	__Asthma	__Autism
__Bladder Infection	__Bleeding disorder	__Cancer-type: _____	__Cerebral Palsy	__Chronic Sinus
__Convulsions/Seizures	__Diabetes	__Eating Disorder	__Epilepsy	__Fainting
__Hearing Loss	__Heart Murmur	__Heart Valves	__Hemophilia	__Hepatitis A/B/C
__Herpes	__Kidney Infection	__Liver Infection	__Measles	__Mononucleosis
__Mouth Sores/Ulcers	__Organ Transplant	__Rheumatic Fever	__Sensory Integration Disorder	
__Shunts _VA _VV _VP	__Syndrome: _____	__Thyroid	__Tuberculosis	__Venereal Disease

Is there anything other information that we need to be aware of regarding your child that has not yet been covered in this form? __Yes __No
Explain: _____
_____

I understand that the information given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's medical status, insurance, and contact information. I understand the late/canceled/failed appointment policy.

Printed Name: _____ Signature: _____ Date: _____