PATIENT REGISTRATION

Parents are welcome to remain with your children.

Today's Date:____________________________________

Welcome! We offer you friendship and extraordinary dental and orthopedic care. Please fill in your answers as thoroughly as possible. This will help in developing a complete dental health program for your child. Of course, all information will be held in strict confidence. By working together, we can find a way to achieve your goal of good dental health and beautiful smiles for your child, in ways that transform the quality of life for your child & for you. Come for the dentistry. Stay for the friendship!

PATIENT INFORMATION

Patient's Name____
FIRST MIDDLE LAST

Nickname______________________________ Date of Birth ____/____/____ Sex: ❑ female ❑ male

Home Street Address ______________________________ Home Phone Number__________________

City____Zip______________________

Cell Phone Number__________________ Phone Number for Appointment Reminder__________________

School______________________________________Grade______________________

Patient's email____

MOTHER'S INFORMATION

Name______________________ ❑ M, ❑ D, ❑ S, ❑ W

Address______________________________

____

SSN ______________ DOB ____/____/____

E-mail address______________________________

Occupation______________________________

Employed by______________________________

Business Address______________________________

Business Phone ______________________________

FATHER'S INFORMATION

Name______________________ ❑ M, ❑ D, ❑ S, ❑ W

Address______________________________

____

SSN ______________ DOB ____/____/____

E-mail address______________________________

Occupation______________________________

Employed by______________________________

Business Address______________________________

Business Phone ______________________________

Names and ages of other children in family ____

Who is your family dentist? ______________________ Office located in what city? ______________________

Whom may we thank for referring you? ____

- Federal law requires that the parent or guardian who brings the child to appointments is responsible for incurred fees.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.
- I certify this information is true and correct to the best of my knowledge.
- I will notify you of any changes in my child's health status or the above information.
- I understand that Little Fish Dental files insurance claims electronically. This is acceptable to me.
- I have been presented a copy of the Notice of Privacy Practices (HIPAA), detailing how my information can be used, and I understand that if I would like a copy of my own records, I may request one at the registration desk.

____

Signature **Relationship to Patient** **Date**

DENTAL HEALTH AND HISTORY

Why did you bring your child to the dentist today? ______________________________

How long has it been since your child's last dental exam? ______________ last tooth cleaning? __________ ❑ First visit ever

For most drinking & cooking do you use: ❑ town water ❑ well-water ❑ bottled water

If well or bottled, has water been tested for fluoride? .... ❑ Yes ❑ No

Results? ______________________________

Does your child take fluoride supplements? .... ❑ Yes ❑ No

Dose ______________________________ Frequency ______________________________

Have there been any injuries to the face, mouth or teeth? .... ❑ Yes ❑ No

Please give dates and descriptions ______________________________

Has your child ever sucked a thumb or fingers? .... ❑ Yes ❑ No

Pacifier? .... ❑ Yes ❑ No

Any other habits? ______________ For thumb, pacifier or other habits until what age? __________

Does your chid have (check all that apply):

- ❑ Snoring
- ❑ Daytime mouthbreathing
- ❑ Nighttime mouthbreathing
- ❑ Tooth grinding
- ❑ Bedwetting now
- ❑ Hearing deficiency
- ❑ Frequent middle ear infections
- ❑ Environmental allergies
- ❑ Taking medications for allergies
- ❑ History of sleep apnea
- ❑ Restless Sleep
- ❑ Speech problems

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

Are there any unusual sounds in ear (clicking) during eating? .... ❑ Yes ❑ No

Has your child ever had an orthodontic examination or orthodontic treatment? .... ❑ Yes ❑ No

Does your child use a sippy cup? .... ❑ Yes ❑ No

Did your child go to sleep with a bottle, with a sippy cup, or while nursing? .... ❑ Yes ❑ No

Until what age? ______________________________

Is your child nervous or frightened during dental visits? If yes, please circle

Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

It would be helpful if you indicate below what things you are looking for most in choosing a dentist for your children

____

Has your child had any unfavorable medical or dental experience? .... ❑ Yes ❑ No

If so, explain ______________________________

MEDICAL HEALTH AND HISTORY

Is your child in good health? .... ❑ Yes ❑ No

Date of last physical examination ______________________________

Is your child now under the care of a physician? .... ❑ Yes ❑ No

List the conditions being treated? ______________________________

Did your child have trouble at birth or during the early years? .... ❑ Yes ❑ No

Please describe ______________________________

Name of Pediatrician or Family Physician ______________________________

Address & Phone ______________________________

Has your child had any serious illness or injury? .... ❑ Yes ❑ No

If so, what was the illness or injury? ______________________ Date __________

Was your child delivered by Caesarean Section? .... ❑ Yes ❑ No

Has your child ever been hospitalized or had surgery? .... ❑ Yes ❑ No

Date: ______________ Reason: ______________________________

Date: ______________ Reason: ______________________________

Have your child's tonsils or adenoids been removed? .... ❑ Yes ❑ No

If yes, when ______________________________

What is the decay rate of your child's siblings? ❑ none ❑ slight ❑ moderate ❑ severe

MEDICAL HISTORY CONTINUED

Does your child have or has your child had any of the following (check all that apply)?

- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Heart murmur
- ❑ Congenital heart lesions
  - ❑ *Heart abnormalities present since birth*
- ❑ Physician has recommended antibiotics before dental procedures
- ❑ Other cardiovascular disease
- ❑ Environmental allergies
- ❑ Hay fever or sinus problems
- ❑ Asthma or breathing problems
- ❑ Hives or skin rash
- ❑ Fainting spells or seizures
- ❑ Diabetes
- ❑ Hepatitis, jaundice, or liver problems (if jaundice, when newborn?) ❑ Yes ❑ No
- ❑ Arthritis
- ❑ Limits on physical activities
- ❑ Tuberculosis
- ❑ Mononucleosis
- ❑ Low blood pressure
- ❑ Thyroid problem
- ❑ Anemia
- ❑ Bone disorders
- ❑ Growth problems
- ❑ Stomach ulcers
- ❑ Kidney problems
- ❑ Birth defect (please describe)______________________
- ❑ Hearing problems
- ❑ Learning problems
- ❑ Behavior problems
- ❑ Mental/emotional problems
- ❑ Blood transfusion
- ❑ HIV (AIDS)
- ❑ Other____

Has your child had abnormal bleeding with previous extractions, surgery, or trauma? .... ❑ Yes ❑ No

Has your child been tested for sickle cell anemia? .... ❑ Yes ❑ No

If yes, what was the result? ____

Does your child take any drug or medicine? .... ❑ Yes ❑ No

If so, what/how often ____

Does your child take any vitamins, supplements? .... ❑ Yes ❑ No

Please list: ____

Has your child ever had an allergic reaction to: (if yes, please describe)______________________

- ❑ Aspirin or ibuprofen
- ❑ Penicillin or other antibiotics
- ❑ Novocaine, Xylocaine or other local anesthetics
- ❑ Other________________________________
- ❑ Codeine
- ❑ Sulfa drugs
- ❑ Foods
- ❑ Latex

Does your child use any complementary or alternative medicines or supplements? .... ❑ Yes ❑ No

Please list ____

Does your child have any mental or physical disability? .... ❑ Yes ❑ No

If so, please explain____

Does your child have any disease, condition or problem not listed above that you think we should know about? ..... ❑ Yes ❑ No

____

What are her/his hobbies or interests?

____

THANK YOU VERY MUCH!

____
Date **Parent / Guardian Signature**

CONSENT FOR TREATMENT - SIGNATURE REQUIRED

1. The undersigned hereby authorizes the taking of x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Trout to make a thorough diagnosis of your child's dental or orthodontic needs.
2. I also authorize Dr. Trout to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment of my child.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Trout choose and employ such assistance as deemed fit to provide recommended treatment.

____
Parent / Guardian Signature **Relationship** **Date** **Witness**

Summary/Notes: ____

____

____
Date Dentist Signature