

REGISTRATION

PATIENT'S NAME _____
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED _____

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

DATE OF BIRTH _____

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: RESIDENCE _____

PATIENT/PARENT EMPLOYED BY _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE: BUSINESS _____

PRESENT POSITION _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

SPOUSE BUSINESS TELEPHONE _____

PRESENT POSITION _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH

YOU _____

PHONE _____ RELATIONSHIP _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment. If my account becomes delinquent (I have a balance still due 90 days from date of service), I agree that I will be liable for all costs, interest and actual attorney's fees incurred (up to and including 50% of the balance due) in the collection of the balance due. Interest will be added at 1% per month on any account due over thirty (30) days. I agree to a broken appointment charge of at least \$25 for any appointment not cancelled at least 24 hours in advance. I understand that the broken appointment charge may be more based on the time and expertise necessary for the services to be rendered.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____

ADDRESS _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE: _____

CONTRACT/POLICY # _____

UNION LOCAL OR GROUP # _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE(IF ANY)

EMPLOYEE NAME _____

BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____

ADDRESS _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE: _____

CONTRACT/POLICY# _____

UNION LOCAL OR GROUP# _____

SOCIAL SECURITY NO. _____

PATIENT OR GUARDIAN'S SIGNATURE _____ DATE _____

CHILD DENTAL/MEDICAL HISTORY

PATIENT'S NAME _____
Last
First
Initial
Date of Birth

PARENT'S NAME _____
Last
First
Initial

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY

1. Is this the child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist? _____
3. Does child eat between meals? YES NO
4. Does child eat excessive sweets, such as candy, soda pop, chewing gum YES NO
5. Does child eat well balanced meals? YES NO
6. Does child brush teeth regularly? YES NO
 How often? _____
7. Do you live in an area without fluoridated water? YES NO
8. Have teeth been treated with fluorides? YES NO
9. Have any cavities been noted in the past? YES NO
10. Were any teeth (baby or permanent) removed by extraction? YES NO
 Was it suggested that the space be maintained? YES NO
 Was appliance placed? YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
 If so, describe _____
12. Has child had any unfavorable dental experiences? YES NO
13. How many children in your family? _____
14. Has anyone in the family, including parents, had orthodontics? YES NO
15. Has child ever received a local anesthetic (Novocaine)? YES NO
16. Has child ever had occlusal sealants? YES NO

MEDICAL HISTORY

1. Is child in good health? YES NO
2. Is child under care of physician? YES NO
 If yes, since when and why? _____
3. Name and address of physician _____

4. Has child had any serious illness? YES NO
 When? _____ What? _____
5. Has child had surgery? YES NO
6. Are you aware of any heart murmurs? YES NO
7. Is child subject to profuse bleeding? YES NO
8. Is child subject to nervous disorders? YES NO
 fainting? YES NO
 dizziness? YES NO
9. Does child have allergies? YES NO
10. Is the child allergic to penicillin, antibiotics, or other drugs? YES NO
11. Is child receiving any medication? YES NO
 What? _____
12. Has child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S/HYGIENIST'S SIGNATURE _____ DATE _____