

# 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 \_\_\_\_\_