Welcome

Age_____ Date_____

Patient's Name_____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

If Minor: Parent's Name_____

How do you wish to be addressed? _____
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence Address_____

City/State/Zip Code_____

Business Address_____

Telephone: Res._____ Bus. _____

Fax_____ Cell Phone #_____

Email _____

Patient/Parent Employer _____

Present Position _____

How Long Held_____

Spouse/Parent Name _____

Spouse's Employer _____

Present Position _____

How Long Held_____

Person Responsible for this account_____

Driver's License No. _____

Method of Payment: Cash ☐ Credit Card ☐ Insurance ☐

Purpose of Visit _____

Other Family Members in this Practice _____

_____

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

_____

Secondary emergency contact

_____

## DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs._____
Name of Insurance Co._____
Address _____
_____
Telephone _____
Program or policy# _____
Social Security No._____
Union Local or Group_____

## DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs._____
Name of Insurance Co._____
Address _____
_____
Telephone _____
Program or policy# _____
Social Security No._____
Union Local or Group_____

**CONSENT:**
I consent to all diagnostic procedures and treatment required for proper dental care by the dentist.

I consent to the dentist's use and disclosure of my records (or my child's records) to the insurance company to obtain payment, and for those activities and health care operations that are related to treatment or payment.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

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

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE_____

# REGISTRATION

# Welcome

Patient's Name_____
Last First Initial Nickname Date of Birth

Parent's/Guardian's Name

**DENTAL HISTORY** - CIRCLE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? . . . . . .YES NO
2. If not, how long since the last visit to a dentist?_____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? . . . . . .YES NO
4. Does your child eat between meals? . . . . . .YES NO
5. Does your child eat sweets, such as candy, soda pop, and chewing gum? . . . . . .YES NO
6. When does your child brush his/her teeth?
   □ Upon arising □ After eating any food □ Right after meals □ Before going to bed
7. How does your child receive Fluoride?
   □ Community water level ____ ppm □ Well water level ____ ppm
   □ Fluoride drops or tablets □ Fluoride rise or gel
8. Have any cavities been noted in the past? . . . . . .YES NO
9. Were any teeth (baby or permanent) removed by extraction?. . . . . .YES NO
   Was it suggested that the space be maintained? . . . . . .YES NO
   Was an appliance placed?. . . . . .YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.?. . . . . .YES NO
    If so, describe _____
11. Has your child had any problem with dental treatment in the past?. . . . . .YES NO
12. Has anyone in the family, including parents, had orthodontics?. . . . . .YES NO
13. Has your child ever received a local anesthetic? . . . . . .YES NO
14. Has your child ever had occlusal sealants? . . . . . .YES NO
15. Does your child think there is anything wrong with his/her teeth?. . . . . .YES NO

**MEDICAL HISTORY**

1. Does your child have a health problem?.. . . . . .YES NO
2. Is your child under care of physician? . .. . . . . .YES NO
   If yes, since when and why? _____
3. Name of physician Phone
   _____
4. Is your child receiving any medication? .. . . . . .YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs. . . . . .YES NO
6. Is your child allergic to or sensitive to any metals or latex?. . . . . .YES NO
7. Does your child have other allergies?. .. . . . . .YES NO
8. Has your child had any serious illness? .. . . . . .YES NO
   When _____ What _____
9. Has your child ever had surgery? . . . .. . . . . .YES NO
10. Does your child have a heart murmur? .. . . . . .YES NO
11. Is surgery contemplated? . . . . . .YES NO
12. Does your child experience severe or prolongated bleeding? . . . . . YES NO
13. Does your child have AIDS or has he/she tested HIV positive? . . . . . .YES NO
14. Has your child tested positive for hepatitis?. . . . . .YES NO
15. Is your child subject to nervous disorders? . . . . . .YES NO
    □ Fainting □ Seizures □ Dizziness □ Behavioral/Learning problems?
16. Does your child have frequent headaches? . . . . . .YES NO
17. Has your child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

**COMMENTS**

I CERTIFIY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PARENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

# CHILD DENTAL MEDICAL HISTORY

PATIENT'S NAME _____
Last First Initial

I hereby authorize payment directly to _____
of the dental benefits otherwise payable to me. (DENTIST'S NAME)

_____
SIGNATURE (INSURED INDIVIDUAL)

_____
DATE

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

_____

_____
ATTENDING D.D.S. NAME

is authorized to provide any insurance company(s), claim administrators(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____
PATIENT OR AUTHORIZED INDIVIDUAL'S SIGNATURE DATE

SIGNATURE ON FILE