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____________

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.____________________

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.

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

COMMENTS

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 (Novacaine)? .... 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.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE ____________________ DATE__________

DENTIST'S/HYGIENIST'S SIGNATURE ____________________ DATE __________