



PATIENT REGISTRATION FORM

Welcome to our office! We sincerely appreciate your selection of our office to serve your child's dental health care needs. We are committed to making their visits with us comfortable, giving personal attention and quality care. **Please** complete all necessary information for us to become acquainted with you, your child and their dental and medical history.

Patient Name _____
(Last) (First) (M.I.)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Gender: _____ Male _____ Female School attending: _____

Emergency Contact: _____ Telephone # _____
(Not living with you/Relation to Patient)

Responsible Party Name: _____
(Last) (First) (M.I.)

Relationship to Patient: Parent _____ Legal Guardian _____ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Social Security Number: _____ Status: Single Married Divorced Widow

Responsible Party Employer: _____ Occupation: _____

Insurance Company Name: _____ Phone #: _____

Group Number: _____ Subscriber: _____ Social Security: _____

Whom may we thank for referring you to our Office: _____

I hereby declare that the above information is correct and complete

Responsible Party (Print Name) _____ Date: _____

Responsible Party Signature: _____ Date: _____

PLEASE COMPLETE ALL MEDICAL AND DENTAL HISTORY ON BACK SIDE

PEDIATRIC MEDICAL HISTORY

Patient Name: _____ Nick Name: _____ Date: _____

Is child regularly seen by a Medical Doctor? _____ Name of Physician _____

Has your child had all immunizations to date? Yes: _____ No: _____ Explain: _____

Has your child ever been Hospitalized or Emergency treatment? Yes: _____ No: _____

If yes, state reason and when: _____

Has your child ever been diagnosed with any of the following condition? Please circle

Allergies	Yes	No	Emotional Problems	Yes	No	Liver Disease	Yes	No
Anemia	Yes	No	Eye Problems	Yes	No	Measles	Yes	No
Arthritis	Yes	No	Hearing Loss	Yes	No	Mental Disorders	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Orthopedic Problems	Yes	No
Brain Injury	Yes	No	Heart Murmur	Yes	No	Pneumonia	Yes	No
Bleeding Disorders	Yes	No	Hepatitis/Liver Disease	Yes	No	Pregnancy	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Rheumatic Fever	Yes	No
Cerebral Palsy	Yes	No	HIV (AIDS)	Yes	No	Scarlet Fever	Yes	No
Convulsions	Yes	No	Hyperactivity	Yes	No	Sinus Problems	Yes	No
Cystic Fibrosis	Yes	No	Jaundice	Yes	No	Stomach Problems	Yes	No
Developmentally Delayed	Yes	No	Kidney Disease	Yes	No	Speech Disorder	Yes	No
Diabetes	Yes	No	Leukemia	Yes	No	Tumors	Yes	No

List all Allergies: _____

List all Medications: _____

DENTAL HISTORY

Is this your child's first Dental Visit? Yes No When was their last dental visit? _____

Does your child brush their teeth regularly? Yes No Does your child smoke? Yes No

Does your child use: Fluoride Vitamins? Yes No Fluoride toothpaste or rinse? Yes No

Has your child had any accidents involving their teeth? Yes No Has your child complained of any pain? Yes No

Explain: _____ Explain: _____

How do you expect your child to react to dental treatment? Very Well _____ Moderately Well _____ Not Well _____

Explain: _____

Is there anything you would like to discuss personally with the dentist who examines your child? Yes No

Explain: _____

If your child has pets, hobbies, special interest, please list: _____

(Signature of Parent or Guardian)

(Date)

(Instructor Signature)

(Date)