

healthy teeth, happy children

PATIENT REGISTRATION

First Name:	Last Name:	Middle Initial:
Preferred Name:		
Responsible Party:		
First Name:	Last N	ame:Middle Initial:
Address:		Address 2:
City, State, Zip:		
		Cell Phone:
E-mail:		☐ I would like to receive email correspondence
Birth date:	Social Security #:	Drivers Lic#:
If you have dental insuran	ice, the responsible party i	s: Primary Policy Holder Secondary Policy Holder
Patient Information:		
Address:		_Address 2:
City, State, Zip:		<u> </u>
Home Phone:	Work Phone:_	Cell Phone:
Sex: □ Female □ Male	Birth date:	Referred By:
Primary Insurance Info	rmation:	
Name of Insured:		_Patients Relationship to Insured: □Child □ Other
Employer ID:		Carrier ID:
Insured Social Security #:		
Employer:		Insurance Company:
Address:		Address:
Address 2:		Address 2:
City State 7in:		City State 7in:

Secondary Insurance Information:

Name of Insured:	Patients Relationship to Insured: Child Other
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	
Address 2:	
City, State, Zip:	City, State, Zip:



Has your child ever been hospitalized or had an operation? Yes No If yes, please explain: Has your child ever had a serious head or neck injury? Yes No If yes, please explain: Is your child taking any medications, pills, or drugs? Yes No If yes, please explain: Is your child on a special diet? Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other If yes, please explain: Does your child have, or has your child had, any of the following? AlDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Renal Dialysis Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis A Yes No Rheumatic Fever Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis Bor C Yes No Rheumatism Yes Anemia Yes No Emphysema Yes No Heipessure Yes No Shingles Yes Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Spina Blifida Yes No Excessive Thirst Yes No Irregular Heartbeat Yes No Spina Blifida Yes No Excessive Thirst Yes No Lewenia Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Storke Yes No Storke Yes No Single Blifida Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Storke Yes No Single Ilimbs Yes Rashing Problem Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes No Sing Climbs Yes Rashing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes No Thyroid Disease Yes No Interculosis Yes No Low Blood Pressure Yes No Tumors or Growths Yes No Choles Pever Blisters Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes No Uveneral Disease Yes No Uveneral Disease Yes No Heart Murmur Yes No Parchitaric Care Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Heart Murmur Yes No Parchitaric Care Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Heart Murmur Yes No Parchitaric Care Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Dis	Is your child under a phy Who is your child's phys	sician's c		ne following questions. w?	Yes	No	If yes, please explai	n:			_	
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Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes No Venereal Disease Y Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes No Yellow Jaundice Y Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No	Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	
Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes No Yellow Jaundice Y Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No	Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Diseas	e Yes	No	Ulcers	Yes	
Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No	Cold Sores/Fever Blisters	s Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	
	Congenital Heart Disorde	r Yes	No	Heart Pace Maker	Yes	No	Radiation Treatme	nts Yes	No	Yellow Jaundice	Yes	
Has your child ever had any serious illness not listed above? Yes No If yes, please explain:	Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Los	s Yes	No			
, . , ,	Has your child ever had	any serio	us illne	ess not listed above?	Yes	No	If yes, please exp	olain:				
												_
Comments:	Comments:											_

__ DATE ____

dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ___