

healthy teeth, happy children

PATIENT REGISTRATION

| First Name: | Last Name: | M | iddle Initial: | | |
|----------------------------|------------------------------|-----------------------------------|--------------------------|--|--|
| Preferred Name: | | | | | |
| Responsible Party: | | | | | |
| First Name: | Last N | ame: | Middle Initial: | | |
| Address: | | | | | |
| City, State, Zip: | | | | | |
| | | Cell Phone | | | |
| E-mail: | | ☐ I would like to recei | ve email correspondences | | |
| Birth date: | Social Security #: | Drivers Lic | Drivers Lic#: | | |
| If you have dental insurar | nce, the responsible party i | s: □ Primary Policy Holder □ S | Secondary Policy Holder | | |
| Patient Information: | | | | | |
| Address: | Address 2: | | | | |
| City, State, Zip: | | | | | |
| Home Phone: | Work Phone:_ | Cell Phone | <u>:</u> | | |
| Sex: □ Female □ Male | Birth date: | Referred By: | | | |
| Primary Insurance Info | rmation: | | | | |
| Name of Insured: | | Patients Relationship to Insured: | □Child □ Other | | |
| Employer ID: | | Carrier ID: | | | |
| | | | | | |
| Employer: | | Insurance Company: | | | |
| Address: | | Address: | | | |
| Address 2: | | Address 2: | | | |
| City State Zin: | | City State Zin: | | | |

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: |



| Who is your child's physician? Has your child ever been hospitalized or had an operation? Yes No If yes, please explain: Is 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 taking any medications, pills, or drugs? Yes No If yes, please explain: Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Other If yes, please explain: Does your child have, or has your child had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes Anaphylaxis Yes No Emphysema Yes No Heppters Yes Angina Yes No Emphysema Yes No High Blood Pressure Yes Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes Artificial Heart Valve Yes No Excessive Thirist Yes No Hives or Rash Yes Ashma Yes No Frequent Diarrhea Yes No Leukemia Yes Blood Disease Yes No Frequent Diarrhea Yes No Lug Disease Yes No Heyen Diarrhea Yes No Frequent Diarrhea Yes No Lug Disease Yes No Heyen Diarrhea Yes No Frequent Headaches Yes No Lug Disease Yes No Heyen Diarrhea Yes No Lug Disease Yes No Genital Herpes Yes No Heart Prevent Diarrhea Yes No Lug Disease Yes No Heyen Diarrhea Yes No Lug Disease Yes No Genital Herpes Yes No Lug Disease Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Concer Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Cond Sores/Fever Blisters Yes No Heart Pace Maker Yes No Recent Weight Loss Yes Convulsions Yes No Heart Pace Maker Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions | nterrelationship with the dentistry your child | |
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| Is your child under a physician's care now? Who is your child's physician's Care now? Who is your child's physician's Care now? Has your child ever been hospitalized or had an operation? 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? Yes No If yes, please explain: Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex 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 Alzheimer's Disease Yes No Drug Addiction Yes No Hepatitis A Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis Bor C Yes Anemia Yes No Easily Winded Yes No Hepatitis Bor C Yes Anemia Yes No Emphysema Yes No High Blood Pressure Yes Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Blood Pressure Yes Artificial Joint Yes No Excessive Bleeding Yes No Hypoglycemia Yes Artificial Joint Yes No Excessive Thirst Yes No Intregular Heartbeat Yes Blood Disease Yes No Frequent Cough Yes No Leukemia Yes Blood Transfusion Yes No Gallacoma Yes No Lung Disease Yes Bruise Easily Yes No Gallacoma Yes No Heart Marturu Yes No Mitral Valve Prolapse Yes Bruise Easily Yes No Gallacoma Yes No Heart Matck/Failure Yes No Parathyroid Disease Yes Condental Heart Disorder Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Congenital Heart Disorder Yes No Heart Attack/Failure Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions | | |
| Who is your child's physician? Has your child ever been hospitalized or had an operation? Yes No If yes, please explain: Is 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? Yes No If yes, please explain: Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Other If yes, please explain: Does your child have, or has your child had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes Anaphylaxis Yes No Emphysema Yes No Heppters Bord Yes Angina Yes No Emphysema Yes No High Blood Pressure Yes Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes Arthritis/Gout Yes No Excessive Thirist Yes No Hypoglycemia Yes Ashma Yes No Each Frequent Diarrhea Yes No Low Blood Disease Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes Blood Transfusion Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes Pruse Easily Yes No Genital Herpes Yes No Lung Disease Yes No Genital Herpes Yes No Hay Frequent Diarrhea Yes No Low Blood Pressure Yes Chemotherapy Yes No Genital Herpes Yes No Heart National Herpes Yes No Parathyroid Disease Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Congenital Heart Disorder Yes No Heart Murmur Yes No Parathyroid Disease Yes Congenital Heart Disorder Yes No Heart Pace Maker Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Parathyroid Disease Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/D | | |
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| Has your child ever had a serious head or neck injury? Is your child taking any medications, pills, or drugs? Is your child on a special diet? Yes No If yes, please explain: Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Other If yes, please explain: Does your child have, or has your child had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemphilia Yes Anaphylaxis Yes No Diabetes Yes No Hepatitis A Yes Anaphylaxis Yes No Drug Addiction Yes No Herpes Yes Anamia Yes No Easily Winded Yes No Herpes Yes Anthritis/Gout Yes No Epilepsy or Seizures Yes No Hiyo Ployoglycemia Yes Artificial Heart Valve Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes Asthma Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes Blood Disease Yes No Frequent Diarrhea Yes No Low Blood Pressure Yes Breathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes Breathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes Breathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes Rol Cancer Yes No Genital Herpes Yes No Low Blood Pressure Yes Rol Cancer Yes No Genital Herpes Yes No Low Blood Pressure Yes Breathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes Chemotherapy Yes No Hay Fever Yes No Parin in Jaw Joints Yes Chemotherapy Yes No Heart Attack/Failure Yes No Parin in Jaw Joints Yes Congenital Heart Disorder Yes No Heart Hrouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Pace Maker Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No North Recent Weight Loss Yes No Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No North Recent Weight Loss Yes No North Recent Weight Loss Yes No North Recent Weight L | | |
| Is your child taking any medications, pills, or drugs? Is your child on a special diet? Yes No If yes, please explain: Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Other If yes, please explain: Does your child have, or has your child had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes Anaphylaxis Yes No Easily Winded Yes No Herpes Yes Anghina Yes No Emphysema Yes No Hiph Blood Pressure Yes Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes Artificial Heart Valve Yes No Excessive Bleeding Yes No Irregular Heartbeat Yes Asthma Yes No Frequent Cough Yes No Leukemia Yes No Frequent Cough Yes No Leukemia Yes No Frequent Cough Yes No Low Blood Pressure Yes Broathing Problem Yes No Genital Herpes Yes No Liver Disease Yes Rolarden Yes No Genital Herpes Yes No Hives or Rash Yes Rolarden Yes No Frequent Headaches Yes No Low Blood Pressure Yes Broathing Problem Yes No Genital Herpes Yes No Low Blood Pressure Yes Rolarden Yes No Low Blood Pressure Yes Rolarden Yes No Genital Herpes Yes No Hive Problems Yes Rolarden Yes No Genital Herpes Yes No Pain in Jaw Joints Yes Chemotherapy Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes Conyculsions Yes No Heart Pace Maker Yes No Radiation Treatments Yes Conyculsions Yes No Heart Pace Maker Yes No Radiation Treatments Yes Conyculsions Yes No Heart Pace Maker Yes No Radiation Treatments Yes Conyculsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Parchylic Care Yes No Heart Pace Maker Yes No Recent Weight Loss Yes No Parchylic Care Yes No Heart Pace Maker Yes No Recent Weight Loss Yes No Parchylic Care Yes No Heart Pace Maker Yes No Recent Weight Loss Yes No Parchylic Care Yes No Heart Pace Maker Yes No Recent Weight Loss Yes No Parchylic Care Yes No Heart Pace Maker Yes No Recent Weight Loss Yes No Parchy | | |
| Is your child on a special diet? Is your child allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Other If yes, please explain: Does your child have, or has your child had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes Anemia Yes No Easily Winded Yes No Herpes Yes Arthritis/Gout Yes No Emphysema Yes No Hives or Rash Yes Artificial Heart Valve Yes No Excessive Bleeding Yes No Hrogolycemia Yes Asthma Yes No Frequent Diarrhea Yes No Leukemia Yes Blood Disease Yes No Frequent Diarrhea Yes No Lung Disease Yes Bruise Easily Yes No Galaucoma Yes No Mitral Valve Prolapse Yes Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes Condot Pressure Yes No Mitral Valve Prolapse Yes Condot Pressure Yes No Mitral Valve Prolapse Yes Congenital Heart Disorder Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Racination Treatments Yes Convoulsions Yes No Recent Weight Loss Yes No Recent Weight Loss Yes Convoulsions Yes No Recent Weight Loss Yes No Racination Treatments Yes Convoulsions Yes No Heart Trouble/Disease Yes No Racination Treatments Yes Convoulsions Yes No Heart Trouble/Disease Yes No Racination Treatments Yes Convoulsions Yes No Heart Trouble/Disease Yes No Racination Treatments Yes Convoulsions Yes No Heart Trouble/Disease Yes No Racination Treatments Yes Convoulsions Yes No Heart Trouble/Disease Yes No Racination Treatments Yes Convoulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes No Recent Weight Loss Yes No Parathyroid Disease Yes No Recent Weight Loss Yes No Parathyroid Disease Yes No Recent Weight Loss Yes No Parathyroid Disease Yes No Recent Weight Loss Yes No Parathyroid Disease Yes No Recent Weight Loss Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Parathyroi | | |
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| Breathing Problem Yes No Frequent Headaches Yes No Low Blood Pressure Yes Bruise Easily Yes No Genital Herpes Yes No Lung Disease Yes Yes No Lung Disease Yes Yes No Cancer Yes No Hay Fever Yes No Pain in Jaw Joints Yes Cold Sores/Fever Blisters Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes No Parathyroid Disease Yes No Pesychiatric Care Yes No Recent Weight Loss Yes | | 1 |
| Bruise Easily Yes No Genital Herpes Yes No Lung Disease Yes Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes Chemotherapy Yes No Hay Fever Yes No Pain in Jaw Joints Yes Chest Pains Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | S . | 1 |
| Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes Chemotherapy Yes No Hay Fever Yes No Pain in Jaw Joints Yes Chest Pains Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | , | 1 |
| Chemotherapy Yes No Hay Fever Yes No Pain in Jaw Joints Yes Chest Pains Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | | 1 |
| Chest Pains Yes No Heart Attack/Failure Yes No Parathyroid Disease Yes Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | | 1 |
| Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Psychiatric Care Yes Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | | 1 |
| Congenital Heart Disorder Yes No Heart Pace Maker Yes No Radiation Treatments Yes Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | | 1 |
| Convulsions Yes No Heart Trouble/Disease Yes No Recent Weight Loss Yes | | 1 |
| | | 1 |
| Has your child ever had any serious illness not listed above? Yes No If yes, please explain: | s No | |
| | | |
| Comments: | | - - - |
| | | - |
| | | _ |
| To the best of my knowledge, the questions on this form Have been accurately answered. I understand that | | |

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE _____