Dr. Mitchell Glass

Pediatric Dentistry of Texarkana

healthy teeth, happy children

PATIENT REGISTRATION

First Name:_____ Last Name: _____ Middle Initial:_____

Preferred Name:_____

Responsible Party:

First Name:_____Last Name:_____Middle Initial:_____

Address: _____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

E-mail: _____ ☐ I would like to receive email correspondences

Birth date:_____Social Security #:_____Drivers Lic#:_____

If you have dental insurance, the responsible party is: ☐ Primary Policy Holder ☐ Secondary Policy Holder

Patient Information:

Address:_____Address 2:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex: ☐ Female ☐ Male Birth date: _____ Referred By:_____

Primary 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: _____

Address 2: _____ Address 2: _____

City, State, Zip:_____ City, State, Zip:_____

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: _____

Address 2: _____ Address 2: _____

City, State, Zip:_____ City, State, Zip:_____

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PATIENT NAME _____ Birth Date_____ Today's Date_____

Although dental personnel primarily treat the area in and around your child's mouth, your child's mouth is a part of your child's entire body. Health problems that your child may Have, or medication that your child may be taking, could Have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Is your child under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Who is your child's physician? _____

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? ☐ Yes ☐ No If yes, please explain: _____

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?

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Breathing Problem ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Tumors or Growths ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pace Maker ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	

Has your child ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:_____

_____

_____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form Have been accurately answered. I understand that providing incorrect information can be 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 _____ DATE _____