NEW PATIENT REGISTRATION FORMS

PATIENT INFORMATION

Child's Full Name: _____ Nickname: _____
DOB: _____ AGE: _____ Gender: _____
Race: _____ Ethnicity: _____ Preferred Language: _____
Address: _____City: _____State: _____ Zip: _____
Who is accompanying the child today? _____

PARENT INFORMATION

Guardian(I) Name: _____ Gender : _____
Address: _____City: _____State: _____Zip: _____
Home: (___) _____-_____ Cell: (___) _____-_____ Email: _____
DOB: _____ SSN: _____ Marital Status: _____

Guardian(II) Name: _____ Gender : _____
Address: _____City: _____State: _____Zip: _____
Home: (___) _____-_____ Cell: (___) _____-_____ Email: _____
DOB: _____ SSN: _____ Marital Status: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. Name: _____ Phone: (____) _____-_____
Address: _____City: _____State: _____Zip: _____
Group/Policy #: _____ I.D. #: _____
Subscriber's Name: _____ Gender: □ Male □ Female
DOB: _____ SSN: _____ Employer: _____

Secondary Insurance Co. Name: _____ Phone: (____) _____-_____
Address: _____City: _____State: _____Zip: _____
Group/Policy #: _____ I.D. #: _____
Subscriber's Name: _____ Gender: □ Male □ Female
DOB: _____ SSN: _____ Employer: _____

We are happy to file your insurance claim for you. However, we do not determine the amount of coverage you will receive, this is done by your insurance company. Any remaining balance or uncovered service is the responsibility of the parent/guardian. Any questions concerning your insurance benefits should be directed to your insurance representative.

PLEASE TURN OVER TO THE SECOND PAGE

DENTAL HISTORY

Dental Concerns:

What is the primary reason for today's visit? ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay

Child's First Dental Visit? If not, Previous Dentist: _____

☐ Yes ☐ No Date Last Visit : _____ Date Last X-Rays: _____

How do you think your child will act toward the Dentist? _____

Has your child ever had a difficult situation associated with previous Dentist? _____

Dental Habits:

Does your child currently…. (Check all that apply)

☐ Suck Thumb/Finger ☐ Bite/Chew Nails ☐ Clench/Grind Teeth ☐ Bottle Feed

☐ Suck/Bite Lips ☐ Use Pacifier ☐ Mouth Breather ☐ Breast Feed

Hygiene Routine: (Check all that apply)

☐ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child: _____/day

☐ Fluoride Mouthwash ☐ Dental Floss: _____/week ☐ Brushing by Parent: _____/day

MEDICAL HISTORY

Child's Physician: _____ Phone: (____) _____-_____Date Last Exam: _____

Is your child followed by a specialist? ☐ Yes ☐ No (explain)_____

If yes, Provide Name:_____ Phone: (____)_____-_____ Date Last Exam: _____

Is your child presently under the care of a physician for any medical problems? _____

History of Hospitalizations/ Operations/ Emergency Room Care:

_____

Has your child been diagnosed and/or for any of the following… (check all that apply)

☐ Heart Murmur/Defect/Surgery
☐ Abnormal Bleeding/hemophilia
☐ Hepatitis
☐ Cancer/Tumor/Leukemia
☐ Cleft Lip/Palate
☐ Epilepsy/Seizures/Convulsions
☐ Cerebral Palsy
☐ Congenital Birth Defects
☐ Diabetes
☐ Liver Disease
☐ Blood Disorder
☐ AIDS/HIV/ARC
☐ Immunocompromised

☐ Autoimmune Disease
☐ Asthma/Reactive Airway
☐ Hearing Problems/Deaf
☐ Vision Problems
☐ Speech Problems
☐ Autism Spectrum
☐ ADD/ADHD
☐ Mental/Cognitive/Social Delay
☐ Kidney Problems
☐ Sickle Cell
☐ Stomach/GI Disorders
☐ Pregnant
☐ Use Tobacco Products

Allergies:

☐ Seasonal
☐ Drug: _____
☐ Food: _____
☐ Other: _____

Current Medications:

_____

_____

Other Condition (specify):

_____

_____

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Dentistry for Children may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Dentistry for Children all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with collection of the account balance, included but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all the terms mentioned above.

Guardian Signature: _____ Date: _____