Roxborough Family Dental

Child Dental Registration

Patient Information

Patient Name _____ DOB ___/___/_____ □ Male □ Female

Address _____ City _____ State ____ Zip _____

School _____

Patient Lives: □ With Both Parents □ With Mother □ With Father □ Other _____

Parent/Guardian Information

Parent/Guardian Name _____ DOB ___/___/_____

Phone Number: Cell _____ Home _____ Work _____

Social Security # _____-_____-_____ □ Married □ Single □ Divorced □ Widowed □ Other

Email Address _____

Employer _____ Address _____

May we use your email and/or cell phone number to send appointment reminders, confirm appointment or other information regarding your child's dental care? □ Yes □ No

Primary Dental Insurance □ N/A

Insurance Company _____ Group # _____ Contact # _____

Subscriber Name _____ Relationship to Patient _____

DOB ___/___/_____ SS/ID#_____

Address (if different from patient) _____ City _____ State ___ Zip _____

Secondary Dental Insurance □ N/A

Insurance Company _____ Group # _____ Contact # _____

Subscriber Name _____ Relationship to Patient _____

DOB ___/___/_____ SS/ID#_____

Address (if different from patient) _____ City _____ State ___ Zip _____

How did you hear about Roxborough Family Dental?

□ Referral (their name) _____ □ Postcard □ Building Sign □ Insurance Company

□ Website □ Social Media □ Yelp Online Review □ Google Online Review □ Welcome letter/brochure

□ I dreamed I should come here □ Other _____

Orthodontic Services

Has your child seen an Orthodontist before? □ Yes □ No Have they had orthodontic treatment? □ Yes □ No

Do you have any concerns about the position or alignment of their teeth? □ Yes □ No

Emergency Contact

Name _____ Relationship to Patient _____

Cell Phone _____ Home Phone _____

Assignment and Release (please sign this section if covered by a dental insurance policy)

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company)

and assign directly to Roxborough Family Dental and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company and furthermore that all dental estimates provided are not a guarantee of coverage or payment and the insurance coverage policy is between myself and the dental insurance company and that Roxborough Family Dental is the dental service provider in the relationship. I authorize the use of my signature on all insurance submissions. Roxborough Family Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services

Print Name of Parent/Guardian _____ Date ____/____/_____

Signature of Parent/Guardian _____

Roxborough Family Dental

Dental and Medical History Information

Dental History

Patient Name: _____ Reason for today's visit: _____

Former Dentist: _____ City/Phone: _____/(_____)_____-_____

Date of last dental exam: _____ Date of last dental x-rays: _____ How often do you brush? _____ Floss?_____

Were there treatment recommendations by your previous dentist that were not completed? □ Yes □ No

Please check all that apply:

□ Bad Breath
□ Bleeding gums
□ Blisters on lips or mouth
□ Burning sensation on tongue
□ Chewing on one side of mouth
□ Cigarette/pipe/cigar smoking
□ Clicking or popping jaw
□ Dry mouth
□ Fingernail biting
□ Food collection between teeth
□ Foreign objects
□ Grinding teeth
□ Gums swollen or tender
□ Jaw pain
□ Jaw tiredness
□ Lip or cheek biting
□ Loose teeth/broken fillings
□ Mouth breathing
□ Mouth pain, brushing
□ Orthodontic treatment
□ Pain around ear
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to heat
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores/growths in mouth

Medical History

Physician's Name: _____ City/Phone: _____/(_____)_____-_____ Date of last visit: _____

Please check all that apply:

□ AIDS/HIV
□ Anemia
□ Arthritis, Rheumatism
□ Artificial Joints
□ Asthma, Use Inhaler: □ Yes □ No
□ Blood Disease
□ Cancer, type _____
□ Chemical Dependency
□ Chemotherapy, when_____
□ Circulatory Problems
□ Congenital Heart Lesions
□ Cortisone Treatments
□ Cough, persistent/bloody
□ Diabetes
□ Dizziness
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Headaches
□ Heart Murmur
□ Heart Problems
□ Hepatitis, type___
□ Herpes
□ High Blood Pressure
□ Jaundice
□ Jaw Pain
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Nervous Problems
□ Pacemaker
□ Psychiatric Care
□ Weight Loss/Gain
□ Radiation Therapy, when_____
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Sinus Trouble
□ Skin Rash
□ Special Diet
□ Stroke
□ Swollen Feet/Ankles
□ Swollen Neck Glands
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Tumor on Head/Neck
□ Ulcer
□ Venereal Disease

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. □ Yes □ No

Do you wear contact lenses? □ Yes □ No

Woman only: Are you pregnant? □ Yes □ No Are you taking birth control pills? □ Yes □ No Are you nursing? □ Yes □ No

Medications (List any medications you are currently taking):

_____

_____

_____

Allergies (Please check all that apply):

□ Aspirin □ Codeine □ Erythromycin □ Latex □ Local Anesthetic □ Metals □ Penicillin □ Sulfa □ Tetracycline □ Other_____

I certify to the accuracy of the above statements regarding my medical and dental history

_____ _____ _____

Signature of patient, parent guardian or representative | Print name of patient, parent guardian or representative | Date