HAROLD KRAUSENECK, D.D.S. MICHAEL O'CONNOR, D.D.S.

CHILD REGISTRATION

Today's date:__________

Child's name:______________________________ Birthdate: ___________Age:_____

Address:___________________________________ City:_________________________

State:___________ Zip:_______________

Home phone #:(___)_______________

Father's name:____

birthdate:_______________________

soc. sec. #:_____________________

employer:________________________________ work phone #:_________

dental ins. **YES** **NO**

IF YES: Name ins. co.:__________________________Group #:_________

Mother's name:____

birthdate:________________________

soc. sec. #:______________________

employer:_________________________________work phone #:_________

dental ins. **YES** **NO**

IF YES: Name ins. co.:__________________________Group #:_________

Whom may we thank for referring you?_____________________________________

DENTAL HISTORY

1. Reason for visit:____
2. When was your child's last dental visit?_________________
3. What texture brush do you use? **SOFT** **MEDIUM** **HARD**
4. Has child complained about dental problems? **YES** **NO**
5. Any unhappy dental experiences? **YES** **NO**
6. Any injuries to mouth-teeth-head? **YES** **NO**
7. Any mouth habits: thumbsucking, pacifier, nail biting, mouth breathing, nursing bottle habits, etc.,______________________________ **YES** **NO**
8. Any unusual speech habits? **YES** **NO**
9. Any lost teeth? **YES** **NO**
10. Have missing teeth been replaced? **YES** **NO**
11. Orthodontic appliances worn now(or previously)**YES** **NO**
12. Does your child brush teeth daily? **YES** **NO**
13. Do you assist child with brushing? **YES** **NO**
    If yes, how often?________________
14. Is fluoride taken in any form? **YES** **NO**
    If yes, how?______________________
15. Child's attitude toward dentistry?_______________________

OVER

HEALTH HISTORY

Child's physician: ____________________

Address: ____________________ Phone: __________

Date of last physical examination: __________

Is child under physician care now? **YES** **NO**

Is child taking any medications? **YES** **NO**

Has child ever been hospitalized? **YES** **NO**

Are there any emotional problems? **YES** **NO**

Other comments: ____________________

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

_____ ANEMIA
_____ ARTIFICIAL JOINT REPLACEMENT
_____ ASTHMA
_____ BLADDER
_____ CEREBRAL PALSY
_____ CHICKEN POX
_____ CHRONIC SINUS
_____ CONVULSIONS
_____ DIABETES
_____ EPILEPSY
_____ FAINTING
_____ HEARING
_____ HEART MURMUR/PROLAPSED VALVE
_____ HEPATITIS
_____ OTHER HEART PROBLEMS
_____ KIDNEY
_____ LIVER
_____ MALIGNANCIES
_____ MEASLES
_____ MONONUCLEOSIS
_____ MUMPS
_____ RHEUMATIC FEVER
_____ THYROID
_____ TUBERCULOSIS
_____ OTHER

ALLERGY TO LOCAL ANESTHETIC? **YES** **NO**

ALLERGY TO PENICILLIN? **YES** **NO**

ALLERGY TO OTHER DRUGS? **YES** **NO**

IF **YES**, PLEASE LIST: __________

THIS INFORMATION WAS DISCUSSED WITH AND GIVEN BY: __________

RELATIONSHIP TO CHILD: __________

WELCOME TO OUR PRACTICE! WE STRIVE TO MAKE EACH OF YOUR CHILDS VISITS PLEASANT AND COMFORTABLE. ***THANK YOU!***

____
[Insert Name of Practice]

<u>SECTION A:</u> The Patient.

Name: ______________________________

Address: ______________________________

Telephone: ______________________________ E-mail: ______________________________

Patient Number: ______________________________ Social Security Number: ______________________________

<u>SECTION B:</u> Acknowledgement of Receipt of Privacy Practices Notice.

I, ______________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: ______________________________ Date: ______________________________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

<u>SECTION C:</u> Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: ______________________________

____

____

Describe the reason why the individual would not sign this form: ______________________________

____

____

<u>SIGNATURE.</u>

I attest that the above information is correct.

Signature: ______________________________ Date: ______________________________

Print name: ______________________________ Title: ______________________________

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE