Bayshore Dental Images

Grant Williams, DMD

Pediatric Patient Registration

Today's Date: _____

Name: _____ Nickname: _____ Birthdate: _____ ❒ Male ❒ Female

Address: _____ Phone #: _____

Father's Name: _____ Mother's Name: _____ Lives with: ❒ Father ❒ Mother

Father's Employer: _____ Work / Cell Phone: _____

Mother's Employer: _____ Work / Cell Phone: _____

For Patient's Covered By Insurance

Subscriber's Name _____ Birth Date _____ SSN# _____-_____-_____

Subscriber's Employer _____ Business Address _____

Insurance Company _____ ID# _____ Group #_____

Secondary Insurance

Subscriber's Name _____ Birth Date _____ SSN# _____-_____-_____

Subscriber's Employer _____ Business Address _____

Insurance Company _____ ID# _____ Group #_____

Dental History

Date of last dental visit _____

Reason for last visit _____

Date of last dental x-rays _____

Has child complained about dental problems ❒ Yes ❒ No

Any unhappy dental experiences, explain _____

If yes, explain: _____

_____

Any dental habits – thumb sucking, pacifier, etc. _____

Childs attitude towards dentistry _____

_____

_____

_____

Does your child brush teeth daily ❒ Yes ❒ No

Do you assist child with tooth brushing ❒ Yes ❒ No

Is dental floss used ❒ Yes ❒ No How often _____

Does your child take any fluoride supplement ❒ Yes ❒ No

Any injuries to mouth / teeth / head ❒ Yes ❒ No

_____

Orthodontic appliances, worn now or ever been ❒ Yes ❒ No

Any other concerns we should know about?

_____

_____

_____

DR. GRANT WILLIAMS, DMD

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(503) 965-0014 ♦ WWW.BAYSHOREDENTAL.COM

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Health History

Child's Physician _____ Phone _____

Is your child currently under care of a physician/doctor/dentist? ❒ Yes ❒ No If yes, explain_____

_____

Is your child currently under the care of a psychiatrist/psychologist for any mental or emotional issues? ❒ Yes ❒ No If yes, explain:

_____

Is your child receiving any medications or drugs (vitamins, prescriptions, etc.) ❒ Yes ❒ No Please list: _____

_____

Is there any excessive bleeding when cut? ❒ Yes ❒ No _____

Has your child ever been hospitalized ❒ Yes ❒ No _____

Has your child ever had any surgery ❒ Yes ❒ No _____

Allergies to drugs/antibiotics, latex, dyes, other? ❒ Yes ❒ No _____

Has Child Had Any History of or Difficulty With Any of The Following:

❒ Anemia	❒ Asthma	❒ Blood / Bleeding Disorders	❒ Cancer	❒ Cerebral Palsy	❒ Chronic Sinus
❒ Convulsions	❒ Diabetes	❒ Ear Aches / Infections	❒ Epilepsy / Seizures	❒ Fainting	❒ Hearing
❒ Heart	❒ Hepatitis	❒HIV/AIDS	❒ Mononucleosis	❒ Rheumatic Fever	❒ Tuberculosis
❒ Other					

Please describe any current medical treatment including Over the Counter & Prescription drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

Agreements

In an effort to improve communications with our patients, Bayshore Dental Images will be E-mailing and/or texting appointment reminders. If you are interested in being part of this service, please enter your information below. Please be aware that this email address may also be used to email your personal information (ie. Receipts, Invoices, Letters) relating to your dental care. Your information is only used for communications with you and other dental professionals. We do **NOT** share or sell personal information.

Personal E-mail: _____@_____.com • Mobile Phone # _____

Please Print Clearly — Your provider may charge a texting fee

I hereby authorize the dentist and staff at Bayshore Dental Images to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. I authorize my insurance company to pay Bayshore Dental Images all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges. This consent is to remain in effect from the date indicated until cancelled in writing.

Authorized signature _____ _____ _____

Relationship to Child — Date

Dr. Comments

_____

_____

Dr. Signature / Date

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