Welcome!

# REGISTRATION

Dentistry for Kids

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503-472-4347

Today's Date _____

PATIENT'S NAME _____
First MI Last

Preferred Name _____

DOB _____ M _____ F _____

Siblings Names _____

_____

PARENT'S NAME _____
First MI Last

Relationship To patient _____

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

WORK _____

CELL _____ DOB _____

PARENT EMPLOYED BY _____

PRESENT POSITION _____

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SPOUSE/OTHER PARENT'S NAME _____
First MI Last

Relationship To patient _____

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

WORK _____

CELL _____ DOB _____

PARENT EMPLOYED BY _____

PRESENT POSITION _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

PURPOSE OF VISIT _____

HOW DID YOU SELECT OUR OFFICE? _____

_____

## DENTAL INSURANCE 1ST COVERAGE

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S SS# _____

EMPLOYER _____

NAME OF INSURANCE CO _____

INS. CO. BILLING ADDRESS _____

INS. CO. PH# _____

SUBSCRIBER'S INSURANCE ID# _____

GROUP OR POLICY # _____

## DENTAL INSURANCE 2ND COVERAGE

SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S SS# _____

EMPLOYER _____

NAME OF INSURANCE CO. _____

INS. CO. BILLING ADDRESS _____

INS. CO. PH# _____

SUBSCRIBER'S INSURANCE 1D# _____

GROUP OR POLICY # _____

# About your Child... Medical and Dental History

## MEDICAL HISTORY

Patients Physician _____

Yes No
( ) ( ) Is patient in good health?
( ) ( ) Is patient under a physicians care? For what? _____
( ) ( ) Does patient have any history of major illness? What? _____
( ) ( ) Has patient ever been hospitalized? For what? _____
( ) ( ) Is the patient receiving any medication/drugs presently? _____
( ) ( ) Does patient have any allergies or drug sensitivity? List _____
( ) ( ) Does patient have chronic colds ( ), sore throat ( ), ear infections ( ), sinus congestion ( ), breathing problems ( )

Has your child ever had any of the following:

( ) Arthritis
( ) Asthma
( ) Autism
( ) Blood Disorders
( ) Cerebral Palsy
( ) Developmental Delays
( ) Diabetes
( ) Epilepsy/Seizures
( ) Emotional Problems
( ) Endocrine Problems
( ) Fainting/Dizziness
( ) Heart Problems
( ) HIV Positive
( ) Liver/Kidney Disease
( ) Nutritional Problems
( ) Prolonged Bleeding
( ) Rheumatic Fever
( ) Speech, Hearing Problem
( ) Tuberculosis
( ) Other (describe below)

Any other significant medical, psychological, or disability problems? ____ Please describe. _____

_____

## DENTAL HISTORY

Previous Dentist _____

Yes No
( ) ( ) Has there been any injuries to the face, mouth or teeth? _____
( ) ( ) Does the patient ever suck their thumb or fingers? _____
( ) ( ) Does the patient have any speech problems? _____
( ) ( ) Does the patient have noticeable problems chewing or swallowing? _____
( ) ( ) Any clicking, popping, or discomfort upon opening or closing their mouth? _____
( ) ( ) Does the patient see a dentist regularly? Date last seen? _____
( ) ( ) Has any previous dental treatment occurred? If yes, what? _____
( ) ( ) Were there any problems with the previous dental treatment? If yes, what ? _____
( ) ( ) Is your drinking water fluoridated?
( ) ( ) Are supplemental fluorides (i.e. rinse, gel, tabs) used? Please describe _____

How often are teeth brushed? _____ Flossed? _____ By whom? _____

Do you have any specific concerns? _____

I acknowledge that this information is correct and hereby authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services.

_____ _____

Signature of Legal Consent Date

## RELEASE:

1. I acknowledge that the above information is accurate.
2. I understand that all fees not covered by insurance are due on the day of service.
3. I authorize my insurance company to pay directly to the dentist.
4. I understand that by signing below that I am responsible for charges for all treatment.

Responsible Party _____ Date _____

PRIVACY STATEMENT:

1. I give permission to the doctors and the staff to share health information to other healthcare providers that are also involved with the patient's care.
2. I have received the practice privacy statement.

Parent / Legal Guardian _____ Date _____