

CHILD REGISTRATION AND HEALTH HISTORY

Name _____ Nickname _____ Sex: M _____ F _____

Birthdate _____ Age _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ E-mail Address _____

Father's Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ How Long Employed? _____

Mother's Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ How Long Employed? _____

Do we have your permission to use your info to text and/or email a message to confirm or otherwise contact you? yes no

RESPONSIBLE PARTY: _____ Relationship to patient _____

Address _____

SS# _____ Birthdate _____

Home Phone _____ Cell Phone _____ Work Phone _____

Whom May We Thank For Referring You? _____

Who would we call in case of Emergency? _____

INSURANCE INFORMATION

Name of Insured Person _____ Relationship to patient _____

Birthdate _____ ID# _____ Date Employed _____

Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Annual Maximum Benefit? _____ Deductible _____

SECONDARY INSURANCE INFORMATION

Name of Insured Person _____ Relationship to patient _____

Birthdate _____ ID# _____ Date Employed _____

Employer _____ Work Phone _____

Insurance Company _____

Annual Maximum Benefit? _____ Deductible _____

OVER >

DENTAL AND MEDICAL HISTORY

How long has it been since you have seen a dentist? _____

Medical Physician's Name _____ Date of last Physical Exam _____

Do you have or have you had any of the following. Please indicate with check mark (✓).

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Allergies to Metal | <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mitro Valve Prolapse | <input type="checkbox"/> Allergies to medicines or drugs | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stents (date _____) | (list below) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Allergies to food, latex, animals, | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Congenital Heart Problems | etc. (list below) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> History of Infective endocarditis | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Surgical Heart Repair | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Any heart problems | <input type="checkbox"/> Artificial Joints/Replacements | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Venereal Disease |
| (list below) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervous Problems | |

Are you pregnant _____ Blood Pressure: S _____ /D _____ / _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. PLEASE LIST MEDICATIONS, DOSAGE AND HOW TAKEN.

PLEASE LIST ALL ALLERGIES, INCLUDING MEDICINE & FOODS:

The Hippa Privacy regulations have been made available to me. _____

Date _____	Signature _____	Relationship to Patient _____
Date _____	Signature _____	Relationship to Patient _____
Date _____	Signature _____	Relationship to Patient _____
Date _____	Signature _____	Relationship to Patient _____
Date _____	Signature _____	Relationship to Patient _____