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 _____

SS#_____ Birthdate_____ Employer _____

Mother's Name _____

Home Phone_____ Cell Phone_____ Work Phone _____

SS#_____ Birthdate_____ Employer _____

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? _____

DENTAL INSURANCE INFORMATION

Name of Insured Person_____ Relationship to patient _____

Birthdate_____ ID# _____ Date Employed _____

Employer_____ Work Phone _____

Insurance Company_____ Group #_____

Annual Maximum Benefit?_____ Deductible _____

SECONDARY DENTAL 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 (✔).

____Pacemaker
____Heart Murmur
____Mitro Valve Prolapse
____Stents (date_____)
____Artificial Heart Valve
____Congenital Heart Problems
____History of Infective endocarditis
____Surgical Heart Repair
____Any heart problems (list below)

____Allergies to anesthetics
____Allergies to Metal
____Allergies to medicines or drugs (list below)
____Allergies to food, latex, animals, etc. (list below)
____Anemia
____Arthritis
____Artificial Joints/Replacements
____Asthma
____Excessive Bleeding

____Circulatory Problems
____Stroke
____Diabetes
____Hepatitis
____Herpes
____HIV/AIDS
____High Blood Pressure
____Low Blood Pressure
____Malignancies
____Radiation Treatments
____Nervous Problems

____Psychiatric Care
____Rheumatic Fever
____Seizures
____Sinus Problems
____Thyroid
____Typhoid Fever
____Tuberculosis
____Ulcer
____Venereal Disease
____Other

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 _____

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Date_____ Signature_____ Relationship to Patient _____