PATIENT REGISTRATION

Patient's First Name:_____

Last Name:_____

Preferred Name:_____

Gender: M / F DOB:_____

Home Address:_____

City:_____ Zip Code: _____

How do you prefer to receive reminders? (Please circle one)

Email / Text Message / Phone Call (home / cell / work)

Father/Guardian's First Name:_____

Last Name:_____

Father's Employer:_____

Occupation:_____

Work #:_____

Home #:_____ Cell #:_____

Home Address (if different from patient's)

:_____

Contact by email (optional):

_____

Mother/Guardian's First Name:_____

Last name:_____

Mother's Employer:_____

Occupation:_____

Work #: _____

Home #: _____

Cell #:_____

Home Address (if different from patient's):

_____

Contact by email (optional):

_____

Is this your child's first visit to a dentist? Y / N

Are other family members patients? Y / N

Is this an emergency? Y / N What are your dental concerns?:

_____

Who can we thank for referring you to our office?

_____

Is there now or has there ever been, any of the following? (Please circle those that apply)

Cavities Toothache Broken Tooth Extracted Teeth Braces Gum Infection

Is your child under a physician's care at this time? Y / N

If yes, please

explain:_____

Name of Physician:_____

Phone #:_____

Does your child have any allergies? Y / N

If yes, please explain:

_____

Has your child had any history of: (Please circle those that apply)

Anemia Emotional Problems Heart Trouble Rheumatic Fever HIV

Asthma Epilepsy Kidney Disease Speech Impediment Hepatitis

Convulsions Excessive Bleeding Liver Disease Tuberculosis Hospitalization

Diabetes Hearing Problem Mental Disturbance Tumors Surgery

Disability, please explain:

_____

Other, please explain:

_____

How is your child's diet? Balanced / "Picky"

Typical snack foods:

_____

Does your child brush: in the morning? Y / N before bed? Y / N after meals? Y / N

Is fluorinated water used in your home? Y / N Has the child ever been treated with fluorides? Y / N

Does your child have any habits such as: (Please circle those that apply)

Oral Breathing Nasal Breathing Tongue Thrust Frontal Tongue Thrust Lateral

Nail Biting Finger Sucking (if so, how long?)_____ Pacifier (if so, how long?)_____

Other Habits, please explain:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be harmful to my child's health. It is my responsibility to inform the dental office of any changes in medical status, insurance, or treatment.

Parent/Guardian

Signature: _____

Print: _____

Date:_____