Pediatric Dentistry

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Patient Registration Form

TELL US ABOUT YOUR CHILD

Child's Name:______________________ Preferred Name:______________ ❑ Male ❑ Female
Child's birthdate:__________ Child's age:________ School:__________________ Grade______
Child's home address:______________________ Zip______ Child's home number:______________
Social Security #:______________________ Siblings Currently at Practice:______________________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name:____________________ Relation:__________ Do you have legal custody of the child? ❑ Yes ❑ No
Whom does patient live with?:______ In case of emergency, contact other than parent:______________________
Whom may be thank for referring you to our office?______________ Email address:______________
What is the best way for our office to confirm your appointments?: *(Circle One)* Text Cell Home # Email

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information:
Name:________________ Date of birth: ______
Address:________________ For how long?:______
____
Employed by:________________ For how long?:______
Occupation:________________
SS#:________________
Cell phone #:________________
Business phone #:________________
Home phone #:________________

Father's Information
Name:________________ Date of birth: ______
Address:________________ For how long?:______
____
Employed by:________________ For how long?:______
Occupation:________________
SS#:________________
Cell phone #:________________
Business phone #:________________
Home phone #:________________

DENTAL INSURANCE COMPANY

Insurance Co. Name:______________ Medicaid #__________ United Healthcare #__________
Insurance Co. address: ______________________ Insurance Co. phone:______________
Group #:______________ ID #______________ Insured's name:______________________

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Beavers, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

______________________________ ______________________________
Signature of Parent/Guardian Date

Date: ____________________

MEDICAL HISTORY

1. Is your child under care of a physician? ❑ Yes ❑ No
   If yes, since when and why? Regular Care ❑ Other ____________
2. Name of physician____________
3. Is your child receiving any medication? ❑ Yes ❑ No
   What?____________
4. Is your child allergic to penicillin, antibiotics or other drugs? ❑ Yes ❑ No
5. Does your child have other allergies? ❑ Yes ❑ No
6. Has your child had any serious illness? ❑ Yes ❑ No
7. Has your child ever had surgery or been hospitalized? ❑ Yes ❑ No
8. Has your child had history of any of the following? **Please check a response for each question:**

Heart trouble, murmur, heart surgery, etc. ❑ Yes ❑ No
Rheumatic fever or scarlet fever ❑ Yes ❑ No
Asthma, TB or lung problems ❑ Yes ❑ No
HIV infection or AIDS ❑ Yes ❑ No
Hemophilia or bleeding problems ❑ Yes ❑ No
Sickle cell anemia/blood disorder ❑ Yes ❑ No
Hepatitis or liver problems ❑ Yes ❑ No
Kidney infection ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Cancer, tumor, leukemia ❑ Yes ❑ No
Thyroid or other glandular problems ❑ Yes ❑ No
Latex or rubber allergy ❑ Yes ❑ No
Frequent headaches ❑ Yes ❑ No
Epilepsy, seizures, fainting ❑ Yes ❑ No
Cerebral palsy or mental retardation ❑ Yes ❑ No
Vision problems ❑ Yes ❑ No
Speech or hearing problems ❑ Yes ❑ No
Emotional or mental problems ❑ Yes ❑ No
Congenital birth defects ❑ Yes ❑ No
Cleft lip or palate ❑ Yes ❑ No
Malignant hyperthermia ❑ Yes ❑ No
Emergency care ❑ Yes ❑ No
Autism ❑ Yes ❑ No
Is parent or patient pregnant? ❑ Yes ❑ No

COMMENTS

(For office use only)

Med. Alert

Purpose of Today's Visit ____________

DENTAL HISTORY

1. When and where was your child's last dental visit?____________
2. What was the purpose of that visit?____________
3. Were any x-rays taken at your child's last dental visit? ❑ Yes ❑ No
4. Did your child have difficulty cooperating? ❑ Yes ❑ No
5. Was/is your child bottle fed? ❑ Yes ❑ No
6. Was/is your child breast fed? ❑ Yes ❑ No
7. If your child has been weaned please indicate at what age?____________
8. Does you child eat between meals? ❑ Yes ❑ No
9. Does your child eat sweets, such as candy, soda, chewing gum? ❑ Yes ❑ No
10. Do you assist/supervise your child's brushing? ❑ Yes ❑ No
11. When does your child brush his/her teeth?
    ❑ upon arising ❑ after eating nay food
    ❑ right after meals ❑ before going to bed
12. Does your child have any form of fluoride? (city or well water, vitamin, rinses, toothpaste) ❑ Yes ❑ No
13. Have any cavities been noted in the past? ❑ Yes ❑ No
14. Were any teeth (baby or permanent) removed by extraction? ❑ Yes ❑ No
15. have there been any injuries to teeth, such as falls, blows, chips, etc.? ❑ Yes ❑ No
16. Has anyone in the family, including parents, had orthodontics? ❑ Yes ❑ No
17. Has your child had a toothache lately? ❑ Yes ❑ No
    If yes, explain:____________
18. Do you expect your child to be cooperative? ❑ Yes ❑ No

CONSENT

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or guardian before any and/or all necessary dental services can be performed by Dr. Nathan Beavers. Authorization is hereby granted as such. I understand I will be consulted before any treatment is rendered.

____________ ____________

SIGNATURE OF PARENT/GUARDIAN DATE