PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Emergency contact: _____

Phone Number: _____

Relation to patient: _____

Referred by: _____

Referred phone #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Child's Health History

Date_____
Patient's First and Last Name _____
Preferred Name _____Sex_____
Age_____Birthday_____Weight_____School_____
What other children in your family have we seen? _____
Address _____ Phone Number_____
Please give a reason for this visit _____

Medical History

Has your child had any history of heart trouble/ heart murmur? ___Y___N
Has your child had rheumatic fever? ___Y___N
Does your child have cancer? ___Y___N
Does your child have epilepsy or seizures? ___Y___N
Does you child have any personal handicaps? If so, please list.

_____
Is your child allergic to any medication or food? If so, please list.

_____
Does your child have prolonged bleeding from cuts? ___Y___N
Has your child had a history of diabetes, kidney problems,
blood disorders or asthma? (If yes circle condition) ___Y___N
Is your child in generally in good health? ___Y___N
Please describe any other medical problems (mental or physical)

_____
Pediatrician (physician) _____
Date of last medical examination_____

Dental History

Is this your child's first visit? ___Y___N
Has your child experienced any unfavorable reaction from any
previous dental or medical care? Please explain _____ ___Y___N

_____
Does your child have any mouth habits (thumb sucking, pacifier, etc.)? ___Y___N
Do you desire complete dental care for your child? ___Y___N
Last examination: _____
Last dental x-rays: _____
Last topical fluoride: _____
Your family dentist: _____
What particular dental problems does your child have? _____

_____
Other comments? _____

_____ _____
Signature of Parent / Guardian Date