



# Patient Registration

**NOTE: Please ensure that all forms are completed using only BLACK Ink.**

## PATIENT INFORMATION

BIRTHDAY	PATIENT NAME	SEX
PATIENT'S ADDRESS		CITY STATE ZIP
HOME PHONE ( )	ALT. PHONE ( )	SOCIAL SECURITY NUMBER
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	SCHOOL AND GRADE	CHILD LIKES TO BE CALLED
PARENT'S MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED		PETS AND HOBBIES

## GENERAL INFORMATION - MOTHER

EMAIL ADDRESS	<input type="checkbox"/> BIOLOGICAL MOTHER <input type="checkbox"/> STEPMOTHER <input type="checkbox"/> GUARDIAN	
DATE OF BIRTH	MOTHER'S NAME	SSN
HOME ADDRESS		CITY STATE ZIP
HOME PHONE ( )	CELL PHONE ( )	OCCUPATION
EMPLOYER	WORK PHONE ( )	DRIVER'S LICENSE NUMBER
IS YOUR CHILD ADOPTED?	IF YES, CHILD'S AGE AT ADOPTION	

## GENERAL INFORMATION - FATHER

EMAIL ADDRESS	<input type="checkbox"/> BIOLOGICAL FATHER <input type="checkbox"/> STEPFATHER <input type="checkbox"/> GUARDIAN	
DATE OF BIRTH	FATHER'S NAME	SSN
HOME ADDRESS		CITY STATE ZIP
HOME PHONE ( )	CELL PHONE ( )	OCCUPATION
EMPLOYER	WORK PHONE ( )	DRIVER'S LICENSE NUMBER

## INSURANCE INFORMATION

NAME OF POLICYHOLDER		RELATIONSHIP TO PATIENT
SUBSCRIBER ID # OR SSN #	BIRTHDATE OF POLICYHOLDER	GROUP OR POLICY #
DENTAL INSURANCE COMPANY	DENTAL INSURANCE COMPANY PHONE NUMBER	
DENTAL INSURANCE ADDRESS		
EMPLOYER	WORK PHONE ( )	
PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?		
ADDRESS	HOME PHONE ( )	

In case of emergency, whom, other than parents, can be notified? \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

The above statements are true and correct. I hereby authorize the doctors of this office, if they should so choose, to initiate a review of my credit history, realizing that any such information will be treated confidentially. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that balances remaining over 90 days from billing will be subject to interest at the rate of 1.5% per month, and agree to pay any and all collection or legal costs incurred should this account be deemed uncollectible.

Signature of Parent or Legal Guardian

Date



PATIENT NAME \_\_\_\_\_

BIRTHDAY \_\_\_\_\_

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**DENTAL INFORMATION**

1. Is this your child's first visit to a dentist?  Yes  No
2. If not, name of previous dentist \_\_\_\_\_ Date of last visit (Month, Day, Year) \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_
3. Were X-rays taken?  Yes  No
4. Was dental treatment completed?  Yes  No
5. Has your child ever had any negative or unpleasant dental experiences?  Yes  No
6. What is your primary reason for seeking dental care? \_\_\_\_\_
7. Has your child complained of any dental problems? \_\_\_\_\_
8. Has your child had any injuries to the mouth, teeth or jaw?  Yes  No  
Please explain \_\_\_\_\_
9. Has your child ever had any of the following? If so, please check.  
 dental cavities  toothaches  
 abscesses (gum boils)  cold sores (fever blisters)  
 stained teeth  bad breath
10. Does (or did) your child have habits that might affect oral health?  
 clenching or grinding teeth  pacifier  
 finger or thumb habits  mouth breathing  
 other
11. Does your child brush daily?  Yes  No Do you assist?  Yes  No Is dental floss used?  Yes  No
12. Do you drink:  city water  well water  bottled water  filtered water
13. How would you describe your child's eating and snacking habits? \_\_\_\_\_
14. What is your child's attitude toward today's visit? \_\_\_\_\_
15. Does your child have problems in concentrating learning cooperating understanding?
16. Is there anything else that you think we should know about your child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Because your child is a minor, it is necessary to obtain signed permission from a parent or legal guardian.

The above statements are, to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any further treatment is performed. I hereby authorize Dr. Phillips, associates, and staff to provide any examinations, x-rays, and procedures to diagnose oral and dental disease, and to provide necessary services with the exception of (if none, please so state) \_\_\_\_\_  
\_\_\_\_\_

I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child.

I also authorize Dr. Phillips and associates to the photographs, x-rays, other materials, and treatment records, without identification of my child, for the purpose of teaching, research, and scientific publications.

This consent shall remain in full force and effect until cancelled.

\_\_\_\_\_  
Patient's Name Signature of Parent or Legal Guardian Date

No treatment will be initiated until a consultation is completed and the individual responsible for child acknowledges understanding and acceptance of treatment and estimated fees.

Thank you for answering these important questions. They will help us to understand your child and your concerns.



PATIENT NAME \_\_\_\_\_

BIRTHDAY \_\_\_\_\_

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**HEALTH INFORMATION**

NAME OF CHILD'S PHYSICIAN		PHYSICIAN'S PHONE ( )	
PHYSICIAN'S ADDRESS	CITY	STATE	ZIP

**HISTORY**

- Is your child currently being treated by a physician?  Yes  No  
If yes, why? \_\_\_\_\_
- Has your child ever been hospitalized?  Yes  No  
If yes, why? \_\_\_\_\_
- Has your child ever received anesthesia or sedation?  Yes  No  
If yes, why? \_\_\_\_\_
- Is your child allergic to anything? (medicine, food)  Yes  No  
If yes, please list \_\_\_\_\_
- Is your child taking any medications at this time?  Yes  No  
If yes, what? \_\_\_\_\_
- Has your child ever had a blood transfusion?  Yes  No
- Does your child have a Heart Murmur?**  Yes  No  
If yes,  Requires Pre Med  No Pre Med Required
- Is your child up to date with immunizations?  Yes  No

**ORGAN AND SYSTEMS**

Has your child ever had any treatment for any the following? Please check yes or no:

- |                              |                             |                          |                              |                             |                  |                              |                             |                   |
|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|-------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Blood – Circulatory      | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Stomach          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Muscles           |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Bones                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Kidney – Bladder | <input type="checkbox"/>     | <input type="checkbox"/>    | Nervous System    |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Endocrine Glands         | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart            | <input type="checkbox"/>     | <input type="checkbox"/>    | Skin              |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Eyes, Ears, Nose, Throat | <input type="checkbox"/>     | <input type="checkbox"/>    | Liver            | <input type="checkbox"/>     | <input type="checkbox"/>    | Tonsils, Adenoids |

Please explain \_\_\_\_\_

**ILLNESS**

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no for each:

- |                              |                             |                       |                              |                             |                             |                              |                             |                         |
|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|-------------------------|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | AIDS                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Hearing Loss                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Scarlet Fever           |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Anemia                | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Condition             | <input type="checkbox"/>     | <input type="checkbox"/>    | Scoliosis               |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Allergy               | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Disease               | <input type="checkbox"/>     | <input type="checkbox"/>    | Sickle Cell Anemia      |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Arthritis             | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Murmur                | <input type="checkbox"/>     | <input type="checkbox"/>    | Sinus Problem           |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Asperger's Syndrome   | <input type="checkbox"/>     | <input type="checkbox"/>    | Hemophilia                  | <input type="checkbox"/>     | <input type="checkbox"/>    | Snoring at Night        |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Asthma                | <input type="checkbox"/>     | <input type="checkbox"/>    | Hepatitis – Type _____      | <input type="checkbox"/>     | <input type="checkbox"/>    | Sore Throats – Frequent |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Autism                | <input type="checkbox"/>     | <input type="checkbox"/>    | Integrated Sensory Disorder | <input type="checkbox"/>     | <input type="checkbox"/>    | Spina Bifida            |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Brain Injury          | <input type="checkbox"/>     | <input type="checkbox"/>    | Jaundice                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Whooping Cough          |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Bronchitis            | <input type="checkbox"/>     | <input type="checkbox"/>    | Latex Allergy               | <input type="checkbox"/>     | <input type="checkbox"/>    | Other _____             |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Cancer                | <input type="checkbox"/>     | <input type="checkbox"/>    | Leukemia                    |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Cerebral Palsy        | <input type="checkbox"/>     | <input type="checkbox"/>    | Measles                     |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Chicken Pox           | <input type="checkbox"/>     | <input type="checkbox"/>    | Mental Retardation          |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Cleft Lip/ Palate     | <input type="checkbox"/>     | <input type="checkbox"/>    | Metal Allergy               |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Convulsions/ Seizures | <input type="checkbox"/>     | <input type="checkbox"/>    | Mumps                       |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Diabetes              | <input type="checkbox"/>     | <input type="checkbox"/>    | Mouth Breathing             |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Downs Syndrome        | <input type="checkbox"/>     | <input type="checkbox"/>    | Nutritional Deficiency      |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Epilepsy              | <input type="checkbox"/>     | <input type="checkbox"/>    | Orthopedic Problems         |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Eye Problems          | <input type="checkbox"/>     | <input type="checkbox"/>    | Pneumonia                   |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Excessive Bleeding    | <input type="checkbox"/>     | <input type="checkbox"/>    | Psychiatric Disorder        |                              |                             |                         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Fainting              | <input type="checkbox"/>     | <input type="checkbox"/>    | Rheumatic Fever             |                              |                             |                         |

I certify that I have read and understand the above questions. I will not hold Dr. Phillips or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

Signature of person completing form/ Relationship to patient \_\_\_\_\_

Date \_\_\_\_\_