Children's Dentistry OF KNOXVILLE

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 ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED	PETS AND HOBBIES

GENERAL INFORMATION - MOTHER

EMAIL ADDRESS	☐ BIOLOGICAL MOTHER ☐ STEPMOTHER ☐ 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	☐ BIOLOGICAL FATHER ☐ STEPFATHER ☐ 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 RESPONIBLE 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

Children's Dentistry OF KNOXVILLE

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.

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PATIENT NAME _____ BIRTHDAY _____

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HEALTH INFORMATION

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

HISTORY

1. Is your child currently being treated by a physician? ☐ Yes ☐ No
   If yes, why? _____
2. Has your child ever been hospitalized? ☐ Yes ☐ No
   If yes, why? _____
3. Has your child ever received anesthesia or sedation? ☐ Yes ☐ No
   If yes, why? _____
4. Is your child allergic to anything? (medicine, food) ☐ Yes ☐ No
   If yes, please list _____
5. Is your child taking any medications at this time? ☐ Yes ☐ No
   If yes, what? _____
6. Has your child ever had a blood transfusion? ☐ Yes ☐ No
7. **Does your child have a Heart Murmur?** ☐ Yes ☐ No
   If yes, ☐ Requires Pre Med ☐ No Pre Med Required
8. 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	No		Yes	No		Yes	No	
☐	☐	Blood – Circulatory	☐	☐	Stomach	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney – Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	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	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Anemia	☐	☐	Heart Condition	☐	☐	Scoliosis
☐	☐	Allergy	☐	☐	Heart Disease	☐	☐	Sickle Cell Anemia
☐	☐	Arthritis	☐	☐	Heart Murmur	☐	☐	Sinus Problem
☐	☐	Asperger's Syndrome	☐	☐	Hemophilia	☐	☐	Snoring at Night
☐	☐	Asthma	☐	☐	Hepatitis – Type _____	☐	☐	Sore Throats – Frequent
☐	☐	Autism	☐	☐	Integrated Sensory Disorder	☐	☐	Spina Bifida
☐	☐	Brain Injury	☐	☐	Jaundice	☐	☐	Whooping Cough
☐	☐	Bronchitis	☐	☐	Latex Allergy			
☐	☐	Cancer	☐	☐	Leukemia	☐	☐	Other_____
☐	☐	Cerebral Palsy	☐	☐	Measles			_____
☐	☐	Chicken Pox	☐	☐	Mental Retardation			
☐	☐	Cleft Lip/ Palate	☐	☐	Metal Allergy			
☐	☐	Convulsions/ Seizures	☐	☐	Mumps			
☐	☐	Diabetes	☐	☐	Mouth Breathing			
☐	☐	Downs Syndrome	☐	☐	Nutritional Deficiency			
☐	☐	Epilepsy	☐	☐	Orthopedic Problems			
☐	☐	Eye Problems	☐	☐	Pneumonia			
☐	☐	Excessive Bleeding	☐	☐	Psychiatric Disorder			
☐	☐	Fainting	☐	☐	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