Patient Registration Form

TELL US ABOUT YOUR CHILD

Child's Name: ______ Nick Name: ______ ☐ Female ☐ Male

Child's Birthdate: ______ Child's Age: ______ School: ______ Grade: ______

Child' Home Address: ______

City: ______ State: ______ Zip Code: ______ Child's Home Phone #: ______

Child's Social Security # : ______

WHO IS ACCOMPANYING THIS CHILD TODAY?

Name: ______ Relation: ______

Do you have legal custody of the child? ☐ Yes ☐ No

Emergency contact other than you (name, and telephone #): ______

Whom may we thank for this referral? ______

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information

Name: ______ Date of Birth: ______

Address: ______

______

How long have you been at this address? ______

Employed By: ______ For How Long? ______

Occupation: ______ SSN: ______

Driver's/ID #: ______

Home Phone: ______ Cell #: ______

Work Phone: ______ Other#: ______

E-Mail: ______

Father's Information

Name: ______ Date of Birth: ______

Address: ______

______

How long have you been at this address? ______

Employed By: ______ For How Long? ______

Occupation: ______ SSN: ______

Driver's/ID #: ______

Home Phone: ______ Cell #: ______

Work Phone: ______ Other#: ______

E-Mail: ______

Dental Insurance Company

Insurance Name: ____ Insurance Address: ____

Insurance Comp. Phone #: ____ Group Policy #: ____

Insured's Name: ____ Your Relationship to Child: ____

Insured's Birthdate: ____ ID #: ____ Insured's Employer: ____

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 for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Kids Smile Pediatric Dentistry otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that 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: ____

Medical History

Date: ____

1) Is your child under the care of a physician? ☐ Yes ☐ No
   If yes since when, & why? ____
2) Name of the physician: ____
3) Is your child receiving any medications? ☐ Yes ☐ No

List of medications: ____

____

4. Is your child allergic to any drugs, such as penicillin? ☐ 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
   Reason: ____
8. Has your child had a history of any of the following?
   Please answer each question:

Heart trouble, murmur, or surgery	☐ 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
Cancer, tumor,leukemia	☐ Yes	☐ No
Sickle cell anemia/blood disorder	☐ Yes	☐ No
Hepatitis or liver problems	☐ Yes	☐ No
Kidney infection	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Comments:
(Office Use Only)

☐ Medical Alert

			Comments: (Office Use Only) ☐ Medical Alert
Thyroid or other glandular problems	☐ Yes	☐ No	
Latex or rubber allergy	☐ Yes	☐ No	
Epilepsy, seizures, fainting	☐ Yes	☐ No	
Cerebral palsy or developmental delay	☐ Yes	☐ No	
Vision problems	☐ Yes	☐ No	
Speech or hearing problems	☐ Yes	☐ No	
Emotional or psychological problems	☐ Yes	☐ No	
Congenital birth defects	☐ Yes	☐ No	
Cleft lip or palate	☐ Yes	☐ No	
Malignant hyperthermia	☐ Yes	☐ No	
Other medical condition	☐ Yes	☐ No	
Is parent or patient pregnant?	☐ Yes	☐ No	

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 age: ____
8. When does your child brush his/her teeth?

☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before bed

9. Do you assist/supervise your child's brushing? ☐ Yes ☐ No
10. Does your child take fluoride supplements? ☐ Yes ☐ No
11. Have any cavities been noted in the past? ☐ Yes ☐ No
12. Were any teeth (baby/permanent) removed by extraction? ☐ Yes ☐ No
13. Have there been any injuries to teeth (falls/blows/chips)? ☐ Yes ☐ No
14. Has anyone in your family, had orthodontics? ☐ Yes ☐ No
15. Has your child had a toothache recently? ☐ Yes ☐ No
16. Do you expect your child to be cooperative? ☐ Yes ☐ No
17. Does your child have other siblings seen by us? ☐ Yes ☐ No

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. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be rendered. I give my consent to Dr. Bagheri and his staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency,abnormality, and/or infection.

Parent / Guardian Signature: ____________________ **Date Signed:** ____________

Please print this form, fill it, and bring it to our office.