

CHILD/YOUTH REGISTRATION

2009
FORM

Date _____

Name of Patient _____ SS# _____
First Middle Last

Date of Birth _____ Age _____ Home # () _____

Father's Full Name _____ SS# _____ Work # () _____

Mother's Full Name _____ SS# _____ Work # () _____

Fax # () _____ E-Mail Address _____

Home Address _____ Zip _____

Past Dental Service (check): None _____ Emerg. only _____ Regular _____ First Visit _____

Favorite Name or Nickname _____ Outside or Special Interest _____

School _____ School Grade _____

Person Responsible for Account _____ Relationship _____

Social Security Number _____ Occupation _____

Employer _____ Work # () _____

Employer's Address _____

Do you have Dental Insurance? Yes _____ No _____ With Whom? _____

Nearest Relative Not Living With You _____ Relationship _____

Address _____ Zip _____ Phone # () _____

Recommended By _____ Patient's Physician _____

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office. Please circle yes or no to the following:

1. Is the patient presently under the care of a physician? Yes No
2. Has the patient ever had abnormal bleeding following a wound? Yes No
3. Is the patient allergic to Penicillin, Novocain or any other medication? Yes No
If so, what? _____
4. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? Yes No
If so, what? _____
5. Is the patient presently taking any medication? Yes No
If so, what? _____
6. Does the patient have any limiting disabilities? Yes No
If so, what? _____
7. Has the patient ever had any of the following?

a) Rheumatic Fever	Yes No	h) Tuberculosis	Yes No
b) Rheumatic Heart Disease	Yes No	i) Diabetes	Yes No
c) Congenital Heart Disease	Yes No	j) Liver Trouble or Jaundice	Yes No
d) Blood Disorder	Yes No	k) Heart Murmur	Yes No
e) Epilepsy or Convulsions	Yes No	l) Hepatitis	Yes No
f) Asthma or Hay Fever	Yes No	m) Eczema or Hives	Yes No
g) Mitral Valve Prolapse	Yes No	n) HIV (Aids)	Yes No
8. Does the patient have any history of missing teeth? Yes No
9. Has the patient been under the care of a physician for any major illness or injury other than those noted above Yes No
If so, what? _____

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment for the child named above in my absence.

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature of Parent or Guardian

Date