IT'S NICE TO GET ACQUAINTED

PATIENT'S REGISTRATION

Child's Name ____________________ Nickname ____________

Age ____________ Date of Birth ____________

Father's Name ____________ Soc. Sec. # ____________

Mother's Name ____________ Soc. Sec. # ____________

Brothers and/or Sisters ____________ Ages ____________

Present Address ____________

City ____________ Zip ____________ Home Phone ____________

Former Residence ____________

City ____________ State ____________ Zip ____________

Person Responsible for Child's Account ____________

Occupation of Father ____________

Occupation of Mother ____________

Employer of Father ____________ Bus. Phone ____________ Ext. ______

Employer of Mother ____________ Bus. Phone ____________ Ext. ______

Business Address (Father) ____________

Business Address (Mother) ____________

Is either parent deceased? ______ Are parents divorced or separated? ______

NOTE: Person accompanying child must be parent or legal guardian.

Name: ____________ Relationship: ____________

I have received a copy of the Notice of Privacy Practices from Dentistry For Children and Adolescents, P. C.

Signature ____________ Date ____________
(Parent or Guardian)

Referred By ____________ Address ____________

Child's Physician ____________

Parent's Dentist ____________

*(All Patients Are Requested To Pay Cash At Their First Appointment Unless Other Arrangements Are Made).

HEALTH HISTORY

CHECK ONE

Yes No

1. Is your child in good health?
2. Does your child have regular medical examinations?
3. Is your child receiving any medicine or drugs? (if yes", explain at the bottom of the page).
4. Is your child sensitive or allergic to penicillin, sulphur or any other drugs? Other allergies: ____________
(List further details at the bottom of the page).
5. Has your child any history of AIDS, HIV positive, heart trouble or heart murmur, diabetes, asthma, hepatitis, rheumatic fever, tuberculosis, kidney or liver disorder, epilepsy, bleeding disorder, anemia or any other medical disorder? (If answer is "yes", underline disorder and explain at the bottom of the page.)
6. Does your child have any physical, mental or muscular disorder? (If "yes", explain diagnosis as told you by your physician, using the area at the bottom of the page).
7. TMJ Syndrome or history of injury to jaw?
______ Noise in joint ______ Pain in joint
(If "yes", explain at the bottom of the page).
8. Has your child experienced any unfavorable reaction from any previous dental or medical care?
9. Does your child have any unusual mouth habit such as: thumbsucking, pacifier, or tongue thrust? (Note Below)
10. Does your child have any speech problems?
11. Has your child been to the dentist in the last six months?
If so, when? ____________
(Date)

I understand and I accept financial responsibility for treatment and that DELINQUENT accounts are placed with Lanier Collection Agency. I give consent to needed dental services and use of proper and acceptable methods to complete same for

Name of Child ____________

Address ____________

City ____________ Zip ____________ Phone ____________

Work Phone ____________

Signed ____________ Date ____________
(Parent or Legal Guardian)

Detailed explanation of health history: ____________

- DO NOT WRITE IN THIS AREA -