## PATIENT REGISTRATION QUESTIONNAIRE

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs. All the information on this form will be kept confidential except as required to file insurance claims on the patient's behalf.

Date ______________________

Patient's Last Name ______________ First ______________ Nickname ______________

Social Security Number ______________________ Birthdate ______________________

Address ______________________ City, State, Zip ______________________

Mother/Guardian ______________________ Birthdate ______________________

Home Phone ______________________ Mobile Phone ______________________

Address ______________________ City, State, Zip ______________________

Employer ______________________ Business Phone ______________________

Years With Firm ______________________

Drivers License Number ______________________

Father/Guardian ______________________ Birthdate ______________________

Home Phone ______________________ Mobile Phone ______________________

Address ______________________ City, State, Zip ______________________

Employer ______________________ Business Phone ______________________

Years With Firm ______________________

Drivers License Number ______________________

Who may we thank for referring you?

Patient ______________________

Friend ______________ Yellow Pages ______________ Other ______________________

Who is financially responsible for this account? ______________________

Signature ______________________ Date ______________________

Is the patient covered under a dental insurance plan?

**IF THE PATIENT IS COVERED UNDER A DENTAL INSURANCE PLAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.**

## DENTAL INSURANCE INFORMATION

In order to insure proper processing of your insurance claim, this form must be completed with all necessary information.

### PRIMARY DENTAL INSURANCE

Policy Holder's Name___________________________________________

Social Security Number _____________________ Birthdate ______________

Home Phone ____________________________

Address _______________________________

City, State, Zip ___________________________________________

Insured's Employer________________________ Occupation _____________

Insurance Company ______________________

Insurance Company Address _____________________________________

Group Policy No. ________________________ Local No.______________

Relationship to Patient _____________________

### SECONDARY DENTAL INSURANCE

Policy Holder's Name___________________________________________

Social Security Number _____________________ Birthdate ______________

Home Phone ____________________________

Address _______________________________

City, State, Zip ___________________________________________

Insured's Employer________________________ Occupation _____________

Insurance Company ______________________

Insurance Company Address _____________________________________

Group Policy No. ________________________ Local No.______________

Relationship to Patient _____________________

P.C.

## CHILD MEDICAL AND DENTAL HISTORY

DATE ____________________

Name ____________________ Nickname ____________
Parent or Guardian ____________________ Child's Birthday ____________
Reason for Visit ____________________
Child's Pediatrician ____________________ Pediatrician's Phone # ____________
List Current Medications ____________________
Has child been seen by a physician in the last year? Yes No
____________________
Has child ever been hospitalized? Yes No
Has child ever had surgery? Yes No
Is child allergic to any medications? Yes No indicate Allergies: ____________
Any other allergies? Yes No
Has child ever had any of the following?
Please circle.

| | | | | COMMENTS (for dental use) |
|---|---|---|---|---|
| Asthma | Yes No | Measles | Yes No | |
| Rheumatic Fever | Yes No | Mumps | Yes No | ____ |
| Heart Murmur | Yes No | Chicken Pox | Yes No | |
| Heart Problems | Yes No | Cold Sores/Herpes | Yes No | ____ |
| Mitral Valve Prolapse | Yes No | Bleeding Problems | Yes No | |
| High Blood Pressure | Yes No | Thyroid Problems | Yes No | ____ |
| Anemia/Blood Problems | Yes No | Liver Problems | Yes No | |
| Sickle Cell Problems | Yes No | Hepatitis/Jaundice | Yes No | ____ |
| Tuberculosis (TB) | Yes No | Diabetes (Sugar) | Yes No | |
| Arthritis | Yes No | Kidney Problems | Yes No | ____ |
| Seizures/Epilepsy | Yes No | Tumor/Cancer | Yes No | |
| Cerebral Palsy | Yes No | AIDS (HIV) | Yes No | ____ |
| Mental Retardation | Yes No | Psychiatric | Yes No | |
| Down's Syndrome | Yes No | Emotional Problems | Yes No | ____ |
| Learning Disability | Yes No | Physical Handicap | Yes No | |
| Hearing Problems | Yes No | Hyperactivity | Yes No | ____ |
| Eye Problems | Yes No | Autism/PDD | Yes No | |

Does child have a history of any of the following?

| | | | |
|---|---|---|---|
| Thumb Sucking | Yes No | Tongue Thrust | Yes No |
| Mouth Breathing | Yes No | Speech Problems | Yes No |
| Fingernail or Object Biting | Yes No | Hearing Problems | Yes No |
| Bed Wetting | Yes No | Cleft Palate | Yes No |
| | | Cleft Lip | Yes No |

. Has there ever been any injury to any of the teeth or mouth? ________ If yes, please explain
____________________
. Is child active in sports? ____________________
. Please list child's hobbies, interests. ____________________
. How often does child brush his/her teeth? ____________________
. Do you help your child brush? ____________________
. At what age did child get first tooth? ________ Walk? ________ Talk? ________
Did child ever take a bottle to bed at night? ____________________
At what age did child stop using the bottle? ____________________
Has any member of your family had any unusual dental problems? ____________________

To the best of my knowledge the above questions have been accurately answered.

____________________
Signature

____________________
Relationship