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WELCOME to our practice



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Patient Registration & History

Patient Information

Date: _____ ID/SS#: _____ Birthdate: ____/____/____

Name of Child: _____
Last Name First Name MI

Gender M F Age: _____ Nickname: _____ Hobbies/Interest: _____

Child's Home Address: _____
Street City State Zip

Mailing Address (if different): _____
Street City State Zip

Language: _____ Race: _____ Ethnicity: _____ Grade Level: _____

Person Financially Responsible: _____ Home #: _____ Work #: _____

Whom may we thank for referring you? Drive By Internet Direct Mail Insurance Plan School/Daycare Friend/Family Other:

Referring Patient Name: _____ Referring GP/Dr. Name: _____

Insurance Information

Mother's/Guardian's Name: _____ <input type="radio"/> Mother <input type="radio"/> Stepmother <input type="radio"/> Guardian	Father's/Guardian's Name: _____ <input type="radio"/> Father <input type="radio"/> Stepfather <input type="radio"/> Guardian
Address (if different from patient's): _____	Address (if different from patient's): _____
DOB: ____/____/____ SS# _____	DOB: ____/____/____ SS# _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
Home Phone: _____	Home Phone: _____
Cellphone: _____	Cellphone: _____
Work Phone: _____	Work Phone: _____
Email: _____	Email: _____
Do you have dental insurance coverage for minor/child? <input type="radio"/> Yes <input type="radio"/> No	Do you have dental insurance coverage for minor/child? <input type="radio"/> Yes <input type="radio"/> No
Plan Name: _____ Phone: _____	Plan Name: _____ Phone: _____
Address: _____	Address: _____
Group #: _____ Policy #: _____	Group #: _____ Policy #: _____

If your child is eligible for treatment under Medical Assistance, please enter their Medical Assistance ID#: _____

Patient Name: _____ Patient Birthdate: ____/____/____

Dental History

Date of last dental visit: _____ For what service?: _____

Has your child complained about dental problems? Yes No Is fluoride taken in any form (including water supply)? Yes No

Does your child brush his or her teeth daily? Yes No Has your child had any mouth, teeth or head injuries? Yes No

Does your child floss his or her teeth daily? Yes No Has your child had any unhappy dental experiences? Yes No

Does your child grind his or her teeth? Yes No Is your child experiencing any dental pain? Yes No

Does your child have any mouth habits (thumbsucking, nail biting, mouth breaking, pacifier, sleeping with bottle, etc.?) Yes No

Medical History

Minor/Child's Physician: _____ City/State: _____ Phone: _____

Date of last physical exam: _____ Results: _____

Is your child under the care of a physician now?? Yes No Please list any medications your child is taking: _____

Is your child taking any medication or drugs? Yes No _____

Does your child experience excessive bleeding? Yes No _____

Has your child had any hospital stays or surgeries? Yes No Please list ALL of your child's allergies: _____

Please explain: _____

Smoking / Tobacco: Yes No Explain: _____

Does your child have any history of or difficulty with any of the following?

- | | | | | | |
|--|---|---|--|--|--|
| AIDS/HIV <input type="radio"/> Yes <input type="radio"/> No | Behavioral issues <input type="radio"/> Yes <input type="radio"/> No | Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart problems <input type="radio"/> Yes <input type="radio"/> No | Measles <input type="radio"/> Yes <input type="radio"/> No | Sinus problems <input type="radio"/> Yes <input type="radio"/> No |
| ADD/ADHD <input type="radio"/> Yes <input type="radio"/> No | Blood disorders <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Mononucleosis <input type="radio"/> Yes <input type="radio"/> No | Skin rash/hives <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Blood transfusions <input type="radio"/> Yes <input type="radio"/> No | Drug/alcohol abuse <input type="radio"/> Yes <input type="radio"/> No | High blood pressure <input type="radio"/> Yes <input type="radio"/> No | Mumps <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Cancer <input type="radio"/> Yes <input type="radio"/> No | Epilepsy <input type="radio"/> Yes <input type="radio"/> No | Kidney problems <input type="radio"/> Yes <input type="radio"/> No | Neurological issues <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Chicken pox <input type="radio"/> Yes <input type="radio"/> No | Fainting <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No | Other <input type="radio"/> Yes <input type="radio"/> No |
| Autism <input type="radio"/> Yes <input type="radio"/> No | Cleft lip/palate <input type="radio"/> Yes <input type="radio"/> No | Hearing impairment <input type="radio"/> Yes <input type="radio"/> No | Liver disease <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell/Trait <input type="radio"/> Yes <input type="radio"/> No | _____ <input type="radio"/> Yes <input type="radio"/> No |

Emergency Contact

In the event of an emergency, whom should we contact? (Other than parent/guardian.)

Name: _____ Relationship: _____ Phone #(s): _____

Name: _____ Relationship: _____ Phone #(s): _____

Minor/child consent: I am the parent, guardian or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including, but not limited to, x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

I certify that I am covered by insurance with _____ and assign directly to Lancaster Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize Lancaster Pediatric Dentistry to release all information necessary to secure the payment of benefits.

To the best of my knowledge, I certify that the above information is complete and correct. I understand that it is my responsibility to inform this office of any changes in my child's medical status or any other information provided in this form.

Signature of Parent, Guardian or Personal Representative _____ Date _____

Please Print Name of Parent, Guardian or Personal Representative _____ Relationship to Patient _____