Tel: 740.475.0700
Fax: 740.475.0703

WELCOME to our practice

Jonathan W. Draney, DDS, MS

LANCASTER pediatric dentistry

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: _____
❍ Mother ❍ Stepmother ❍ Guardian

Address (if different from patient's):_____

_____

DOB:____/____/____ SS# _____

Employer:_____

Employer Address:_____

Home Phone: _____

Cellphone: _____

Work Phone: _____

Email: _____

Do you have dental insurance coverage for minor/child? ❍ Yes ❍ No

Plan Name: _____ Phone:_____

Address: _____

Group #: _____ Policy #:_____

Father's/Guardian's Name: _____
❍ Father ❍ Stepfather ❍ Guardian

Address (if different from patient's):_____

_____

DOB:____/____/____ SS# _____

Employer:_____

Employer Address:_____

Home Phone: _____

Cellphone: _____

Work Phone: _____

Email: _____

Do you have dental insurance coverage for minor/child? ❍ Yes ❍ No

Plan Name: _____ Phone:_____

Address: _____

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 / Tabacco: Yes No Explain: _____

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

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

Please Print Name of Child/Minor

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

Name of Insurance Company (if applicable)

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