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PATIENT REGISTRATION FORM

Child's Name: ______________________ Preferred Name: ______________ ◇Male ◇Female
Child's birth date: ______________ Child's age: ____ School: ______________ Grade: ________
Child's home address: ______________________ City: ________ State: ______ Zip: ________
Child's home number: ____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: ______________ Relation: __________ Do you have legal custody of the child? __________ ◇Yes ◇No
In case of emergency, contact (name and phone#): ______________________________
Whom may we thank for this referral? ______________________________

PERSON RESPONSIBLE FOR ACCOUNT

Father's information: ______________________
Marital status ◇S ◇M ◇D ◇Other: ______________
Name: ______________ DOB______________
Address: ______________________
Employed by:______________________
Occupation: ______________________
SS#: ______________________
Business Phone: ______________________
Home Phone: ______________________
Mobile Phone: ______________________
Email: ______________________

Mother's Information: ______________________
Marital status ◇S ◇M ◇D ◇Other: ______________
Name: ______________ DOB______________
Address: ______________________
Employed by: ______________________
Occupation: ______________________
SS#: ______________________
Business Phone: ______________________
Home Phone: ______________________
Mobile Phone: ______________________
Email: ______________________

DENTAL INSURANCE COMPANY

Insurance Co. Name: ______________________ Insurance Co. Phone: ______________________
Insurance Co. Address: ____
Group# (Plan, Local or Policy#) ______________________ Member# or ID# ______________________
Insured's Name: ______________________ Relationship to Child: ______________________
Insured's birthday: ______________ SS#: ______________ Insured's employer ______________
Do you have secondary insurance Yes No If yes, with whom? ______________________________

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to EVPD, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of the services not paid, in whole or in part, by my dental care payor.

Signature of Parent/Guardian______________________________________ Date ______________

MEDICAL HISTORY

1. Is your child under care of a physician? .... ✧Yes ✧No
   If yes, since when and why? ____
2. Name of physician? ____
3. Is your child receiving any medication? .... ✧Yes ✧No
   List current medications: ____
4. Is your child allergic to any drugs, such as Penicillin? .... ✧Yes ✧No
5. Does your child have any other allergies? .... ✧Yes ✧No
6. Has your child had any serious illness? .... ✧Yes ✧No
7. Has your child ever had surgery or been hospitalized? .... ✧Yes ✧No

Comments
(For office use only)

Med. Alert

Has your child had a history of any of the following?

Please select a response to each question.

Heart trouble, murmur, or surgery .... ✧Yes ✧No
Rheumatic fever or scarlet fever .... ✧Yes ✧No
Asthma, TB, or lung problems .... ✧Yes ✧No
HIV infection or AIDS .... ✧Yes ✧No
Hemophilia, Sickle Cell Disease or other bleeding problems .... ✧Yes ✧No
Hepatitis or liver problems .... ✧Yes ✧No
Kidney Infection .... ✧Yes ✧No
Diabetes .... ✧Yes ✧No
Cancer, tumor, or leukemia .... ✧Yes ✧No
Thyroid or other glandular problems .... ✧Yes ✧No
Latex or rubber allergy .... ✧Yes ✧No
Epilepsy, seizures, fainting .... ✧Yes ✧No
Cerebral palsy or developmental delay .... ✧Yes ✧No
Autism Spectrum Disorder or sensory sensitivities .... ✧Yes ✧No
Vision problems .... ✧Yes ✧No
Speech or hearing problems .... ✧Yes ✧No
Emotional or psychological problems .... ✧Yes ✧No
Congenital birth defects .... ✧Yes ✧No
Cleft lip or palate .... ✧Yes ✧No
Malignant hyperthermia .... ✧Yes ✧No
Other medical condition .... ✧Yes ✧No
Is parent or patient pregnant .... ✧Yes ✧No

PURPOSE OF TODAY'S VISIT ____

DENTAL HISTORY

1. When and where was your child's last dental visit? _______________
   ____
2. What was the purpose of that visit? ____________________
3. Were x-rays taken at your child's last dental visit? .... ✧Yes ✧No
4. Did your child have difficulty cooperating? .... ✧Yes ✧No
5. Was/is your child bottle fed? .... ✧Yes ✧No
6. Was/is your child breast fed? .... ✧Yes ✧No
7. If you child has been weaned please indicate at what age: _____
8. When does your child brush his/her teeth? .... ✧Upon rising
   ✧After eating any food ✧Right after meals ✧Before going to bed
9. Do you assist/supervise your child's brushing? .... ✧Yes ✧No
10. Does your child take fluoride supplements? .... ✧Yes ✧No
11. Have any cavities been noted in the past? .... ✧Yes ✧No
12. Were any teeth (baby or permanent) removed by extraction? .... ✧Yes ✧No
13. Have there been any injuries to teeth, such as falls, blows, chips, etc.?.. ✧Yes ✧No
14. Has anyone in the family, including parents, had orthodontics? .... ✧Yes ✧No
15. Has your child had a toothache recently? .... ✧Yes ✧No
    If yes, explain why: ____
16. Do you expect your child to be cooperative? .... ✧Yes ✧No
17. Does your child have other siblings seen by us? .... ✧Yes ✧No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. James C. Johnson, Dr. Blake R. Schow and their staff to perform such treatments, services, medication, behavior management techniques, local anesthesia, and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Signature of Parent/Guardian____ Date ____________________