

Patient Registration

Patient's Name _____ Nickname _____ ☐ Male ☐ Female

Date of Birth ____/____/____ Age _____

Address where child lives Street _____ Apt. _____

City _____ State _____ Zip _____

Telephone: Res. _____ Cell _____ Alt. # _____

Full name of adult that child lives with 1) _____

Relationship _____ Date of Birth ____/____/____ SS# _____

2) _____

Relationship _____ Date of Birth ____/____/____ SS# _____

Insurance Information #1

Insured's Name _____ Date of Birth ____/____/____

Address _____ Phone # _____

Social Security # _____

Employer name and address _____

_____ Employer Phone # _____

Insurance Company _____ Phone # _____

Group # _____ Member ID _____

Insurance Information #2

Insured's Name _____ Date of Birth ____/____/____

Address _____ Phone # _____

Social Security # _____

Employer name and address _____

_____ Employer Phone # _____

Insurance Company _____ Phone # _____

Group # _____ Member ID _____

Consent

I consent to the diagnostic procedures and treatment by the dentists affiliated with Pediatric Dental Specialists of Indiana, P.C. necessary for proper dental care. I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my child's records to the following persons who are involved in my child's care or payment for that care: _____ My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. I agree to pay all costs of collection including, but not limited to, court costs and reasonable attorney's fees. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I attest to the accuracy of the information on this page.

Parent's/Guardian's Signature: _____ Date: ____/____/____

Patient Dental/Medical History

Dental History

1. Is this your child's first visit to a dentist? Yes No
If not, who was the previous dentist and when? _____
2. Were any x-rays or radiographs taken at the last dental visit? Yes No
3. Has your child had any problems with dental treatment? Yes No
4. Has your child ever received a local anesthetic? Yes No
5. Have any cavities been noted in the past? Yes No
6. Have there been any injuries to teeth...falls, blows, chips?..... Yes No
If so describe _____
7. Does your child use a sippy cup in between meals? Yes No
8. How often does your child/you brush his/her teeth?
☐ Upon arising ☐ After meals ☐ Before going to bed
9. Does your child have a pacifier or thumb sucking habit? Yes No
10. Do you floss your child's teeth? Yes No
11. Has your child ever had occlusal sealants? Yes No
12. Is your child self conscious about his/her teeth? Yes No
13. Has anyone in the family had orthodontics? Yes No

Medical History

1. Does your child have any health problems?..... Yes No
2. Name of physician _____
3. Is your child taking any medications?..... Yes No
If yes, list: _____
4. Is your child allergic to penicillin, antibiotics or other meds? Yes No
5. Is your child allergic or sensitive to any metals or latex? Yes No
6. Does your child have other allergies? Yes No
7. Has your child had a serious illness? Yes No
When _____ What _____
8. Has your child ever had surgery? Yes No
9. Does your child have a heart murmur? Yes No
10. Does your child have asthma? Yes No
11. Does your child experience severe or prolonged bleeding? Yes No
12. Does your child have AIDS or been tested HIV positive? Yes No
13. Has your child been tested positive for hepatitis? Yes No
14. Is your child subject to nervous disorders? Yes No
☐ Fainting ☐ Seizures ☐ Dizziness ☐ Behavioral/Learning problems
15. Does your child have frequent headaches? Yes No
16. Has your child had a history of: (Circle appropriate responses)
diabetes, heart trouble, asthma, kidney infection, rheumatic fever, autism,
epilepsy, cerebral palsy, liver problems, congenital birth defects, mental
handicap, sleep apnea, cancer, infections, speech impairments

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's/Guardian's Signature _____ Date ____/____/____

Dentist's Signature _____ Date ____/____/____