PATIENT REGISTRATION FORM

Please Print **Date:**

Who can we thank for referring you to our office? ____________________

Patient Name____________________
(First) (Middle) (Last)

Preferred Name (if applicable)____________________ DOB____________ Gender: Male Female

Patients Address ____________________ Cell Phone # ____________

____

Mother or Legal Guardian Information

Name: ____________________ DOB: ____________

Address (please write "Same" if address is same as patient): ____________________

____________________ Phone: ____________

Father or Legal Guardian Information

Name: ____________________ DOB: ____________

Address (please write "Same" if address is same as patient): ____________________

____________________ Phone: ____________

FOR PATIENTS COVERED BY INSURANCE

Subscribers Name____________________DOB____________SS#____________

Subscribers Employer____________________Relationship to Patient____________________

Dental Insurance Company____________________

Group #____________________ Subscriber ID #____________________

SECONDARY INSURANCE (if applicable)

Subscribers Name____________________DOB____________SS#____________

Subscribers Employer____________________Relationship to Patient____________________

Dental Insurance Company____________________

Group #____________________ Subscriber ID #____________________

Are there other children in your family?

Name(s): ____________________ Age: ______ Name(s): ____________________ Age: ______

____________________ Age: ______ ____________________ Age: ______

____________________ Age: ______ ____________________ Age: ______

Patient Name: **HEALTH HISTORY**

Childs Physician: ______________________________ Phone: ______________

Address: ______________________________

Date of last physical exam: ______________________________

	Yes	No
Is your child under care of a physician/doctor/dentist? Please Explain	☐	☐
Is your child under the care of a psychiatrist/psychologist for any mental or emotional issues? Please Explain	☐	☐
Has your child ever been hospitalized? Please Explain	☐	☐
Is there any excessive bleeding when cut?	☐	☐

Has your Child had any history or difficulty with the following (please circle)

Anemia	Asthma	Cerebral Palsy	Chronic Sinus	Blood/Bleeding Disorders	Learning Disability
Convulsions	Diabetes	Epilepsy/Seizures	Fainting	Bone/Joint Replacement	Speech Problems
Hearing	Heart	Hepatitis	HIV/AIDS	Ear Aches/Infections	Tobacco Use (Teen)
Liver	Poor Vision	Pregnancy (teen)	Rheumatic Fever	Mononucleosis	Thyroid
		Cancer	Kidney	Tuberculosis	Genetic Testing

Has your child been tested for any problem or condition not metioned above? ______________________________

Please describe any current medical treatment, pending surgery, recent injuries or any other information we should be aware of ______________

HEART MURMUR

	Yes	No
Has your child ever been diagnosed with a heart murmur?	☐	☐
If yes, have you been instructed to take antibiotic prophylaxis prior to dental treatment?	☐	☐

***If your child has been diagnosed with a Heart Murmur but does not required antibiotics,**

our practice REQUIRES documentation from the child's physician stating Antibiotic Prophylaxis is not necessary.

ALLERGIES & MEDICATIONS

Has your child had an allergic reaction to medications or food? i.e. Amoxicillin, sulfur drugs, asprin, local anesthetics, latex, nuts, fruits, etc. YES NO (circle one)

Allergy To:	Reaction Type:	Treatment:

Is your child currently taking any medication(s)? (including prescription and over-the-counter medications) YES NO (circle one)

Medication:	Dose:	Frequency:

Pharmacy:	Phone:	Address:

Parent Signature:

Print	Sign	Date

DENTAL HISTORY

Is this your childs first visit to the dentist? YES NO

Date of last dental visit: ______________________________

For what service (cleaning, emergency visit, filling) ______________________________

Date of last x-rays: ______________________________

	Yes	No		Yes	No
Does your child brush their teeth daily?	☐	☐	Do you assist your child with brushing?	☐	☐
Any injuries to mouth, head, or teeth? ____________________	☐	☐	Is dental floss used/how often? ____________________	☐	☐
			Does your child take any fluoride supplements?	☐	☐
Has your child complained about dental problems? Explain	☐	☐	Orthodontic appliances, worn now or in the past?	☐	☐
Any unhappy experiences? Explain ____________________	☐	☐	How would you describe your child? Shy Frightened		
Any dental habits - thumb sucking, pacifier, etc ______________	☐	☐	Apprehensive Confident		

ADDITIONAL INFORMATION

How does your child react to their physician? ______________________________

How does your child react to having his/her haircut? ______________________________

School Information:

School Name	Teacher	Grade

Does your child have any interests or hobbies? ______________________________

Does your child have any distinguishing marks (including birthmarks, scars, or tattoos) on any part of the body? ______________________________

Is there any additional information that you think might be useful in treating your child?

*** Required** **SIGNATURE AUTHORIZATION FOR INSURANCE**

I hereby authorize my insurance company to pay Leslie A. Olton, DMD or Michelle Daniels, DMD for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges for services rendered whetheror not it is covered by my insurance.

Signature: ____

*** Required** **INFORMED CONSENT FOR PARENTS/GUARDIANS ACCOMPANYING THE CHILD**

I hereby authorize the dentist and staff at We Care For Kids Dental to perform diagnostic aids including an examination, x-rays, photographs, cleaning, and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. This consent is to remain in effect for the date indicated until cancelled in writing.

Signature: ____

***Required** **HIPAA**

Receipt of the Notice of Privacy Practices

Patients Name: ____

Date Notice was effective: September 23, 2013

I have reviewed this office's Notice of Privacy Practices. I am aware that a copy of this Notice is available for review on the company website at www.WeCareForKidsDental.com, as well as posted in the waiting room.
You have the right to a paper copy of this Notice. If you wish to obtain a paper copy, please request a copy from the front desk.

Full Name & Relationship of Personal Representative to Patient:

Print Name/Relationship: ____

Signature: ____ Date: _____________________

If you would like a copy of the HIPAA Act, we have copies available on our website as well as at the front desk at your request