SOUTH GEORGIA PEDIATRIC DENTISTRY

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Patient Registration Form

TELL US ABOUT YOUR CHILD

Child's Name: _____ Nickname _____ ☐ Female ☐ Male

Child's Birthdate _____ Childs Age _____ School _____ Grade _____

Child's Home Address _____ City _____ State _____ Zip Code _____

Child's Home Phone # _____ Social Security # _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relation _____ Do you have legal custody of the child? ◯ Yes ◯ No

Emergency contact other than you (name and telephone #) _____

Whom may we thank for this referral? _____

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information

Name: _____ Date of Birth _____

Address _____

How long at this address? _____

Employed By _____ For How Long? _____

Occupation _____ SSN _____

Driver's License # _____ Home Phone _____

Work Phone _____ Cell Phone _____

E-Mail _____

Father's Information

Name: _____ Date of Birth _____

Address _____

How long at this address? _____

Employed By _____ For How Long? _____

Occupation _____ SSN _____

Driver's License # _____ Home Phone _____

Work Phone _____ Cell Phone _____

E-Mail _____

DENTAL INSURANCE COMPANY

Insurance Co. Name _____ Insurance Co. Address _____

Insurance Co. Phone _____ Group/Policy # _____

Insured's Name _____ Relationship to Child _____

Insured's Birthdate _____ ID# _____ Insured's Employer _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons 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 Dr. Thomas, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

Signature of Parent/Guardian _____ Date _____

Date _____

COMMENTS (*office use only*)

Med. Alert

MEDICAL HISTORY

1. Is your child under the care of a physician?_____ ◯ Yes ◯ No
   If yes, since when and when and why? _____
2. Name of physician _____
3. Is your child receiving any medications?_____ ◯ Yes ◯ No
   List current medications _____
4. Is your child allergic to any drugs, such as penicillin?_____ ◯ Yes ◯ No
5. Does your child have 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
8. Has your child had a history of any of the following? Please answer 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 or bleeding problems_____ ◯ Yes ◯ No
   - Sickle cell anemia/blood disorder_____ ◯ Yes ◯ No
   - Hepatitis or liver problems_____ ◯ Yes ◯ No
   - Kidney infection_____ ◯ Yes ◯ No
   - Diabetes_____ ◯ Yes ◯ No
   - Cancer, tumor,leukemia_____ ◯ Yes ◯ No
   - Thyroid or other glandula problems_____ ◯ Yes ◯ No
   - Latex or rubber allergy_____ ◯ Yes ◯ No
   - Epilepsy, seizures, fainting_____ ◯ Yes ◯ No
   - Cerebral palsy or developmental delay_____ ◯ Yes ◯ No
   - Vision problems_____ ◯ Yes ◯ No
   - Speech or hearing problems_____ ◯ Yes ◯ No
   - Emotional or psychological problems_____ ◯ Yes ◯ No
   - Congential 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 _____

Medical History

1. When and where was your child's last dental visit? _____
2. What was the purpose of that visit? _____
3. Were any 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 your child has been weaned, please indicate age _____
8. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before 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 (falls/blows/chips)?____ ◯ 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, please explain: _____
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 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 service can be rendered. I give my consent to Dr. Thomas and her staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency,abnormality, and/or infection.

Parent/Guardian Signature _____ Date Signed _____

Print Form on your printer and bring to our office