Jonesboro Pediatric Dental Group

Summer B. Tyson, DDS

PATIENT REGISTRATION

First Name:_____ Last Name: _____ Middle Initial: _____

Preferred Name:_____

Responsible Party:

First Name:_____Last Name: _____Middle Initial: _____

Address: _____Address 2: _____

City, State, Zip: _____

Home Phone:_____Work Phone:_____Cell Phone:_____

E-mail: _____ ☐ I would like to receive email correspondences

Birth date:_____Social Security #: _____Drivers Lic#: _____

If you have dental insurance, the responsible party ☐ Primary Policy Holder ☐ Secondary Policy Holder

Patient Information:

Address:_____Address 2: _____

City, State, Zip: _____

Home Phone:_____Work Phone:_____Cell Phone:_____

Sex:☐ Female ☐Male Birth date: _____ Referred By: _____

Primary Insurance Information:

Name of Insured:_____Patients Relationship to Insured:☐ Child ☐ Other

Employer ID: _____Carrier ID: _____

Insured Social Security #: _____Insured Birth date: _____

Employer:_____ Insurance Company: _____

Address:_____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Patients Relationship to Insured: ☐ Child ☐ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

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PATIENT NAME _____ Birth Date_____ Today's Date_____

Although dental personnel primarily treat the area in and around your child's mouth, your child's mouth is a part of your child's entire body. Health problems that your child may Have, or medication that your child may be taking, could Have an important interrelationship with the dentistry your child will receive. Thank you for answering the following questions.

Is your child under a physician's care now? Yes No If yes, please explain: _____
Who is your child's physician? _____
Has your child ever been hospitalized or had an operation? Yes No If yes, please explain: _____
Has your child ever had a serious head or neck injury? Yes No If yes, please explain: _____
Is your child taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Is your child on a special diet? Yes No If yes, please explain: _____

Is your child allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other If yes, please explain:

Does your child have, or has your child had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Has your child ever had any serious illness not listed above? Yes No If yes, please explain:_____
_____
_____
Comments: _____
_____
_____

To the best of my knowledge, the questions on this form Have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____