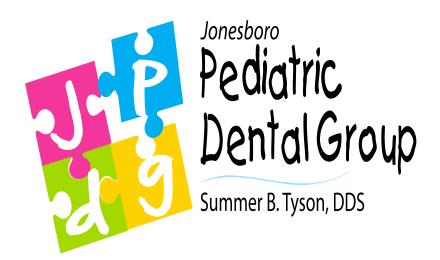


## **PATIENT REGISTRATION**

First Name:	Last Name:	Middle Initial:
Preferred Name:		
Responsible Party:		
First Name:	<u>Last Name:</u>	<u>M</u> iddle Initial:
Address:	A	ddress 2:
City, State, Zip:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		I would like to receive email correspondence
Birth date:	Social Security #:	Drivers Lic#:
	nce, the responsible party 🔲 Prin	nary Policy Holder Secondary Policy Holder
Patient Information:	۸	ddwass 2.
		ddress 2:
		Cell Phone:
<u></u>		d By:
Primary Insurance Inform	ation:	
Name of Insured:	Patients	Relationship to Insured: Child Other
Employer ID:	<u>C</u> arrier ID	:
Insured Social Security #:	In	sured Birth date:
Employer:	Insur	ance Company:
		ess:
Address 2:	Addr	ess 2:
City State 7in:		State 7in:

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:



					e takin	g, could Have an importa	ant inte	rrelatio	nship with the dentistry your	r child	
will receive. Thank you for answering the following questions ls your child under a physician's care now? Who is your child's physician?		Yes	No	If yes, please explain: _							
Has your child ever beer		zed or	had an operation?	Yes	No	If ves. please explain:					
Has your child ever had	•		•	Yes							
Is your child taking any medications, pills, or drugs? Is your child on a special diet?		, ,	Yes								
		Yes	No	If yes, please explain: _							
Is your child allergic to a	ny of the	followi	ng?								
Aspirin	Penicillin		Codeine	Acrylic		Metal Latex		Local	Anesthetics		
	f yes, ple	ase ex		., .							
Does your child have, or	has your	child h	nad, any of the followir	ıg?							
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	
Asthma	Yes	No	Fainting Spells/Dizzine		No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	
Cold Sores/Fever Blisters		No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	
Congenital Heart Disorde Convulsions	r Yes Yes	No No	Heart Pace Maker Heart Trouble/Disease	Yes Yes	No No	Radiation Treatments Recent Weight Loss	Yes Yes	No No	Yellow Jaundice	Yes	
Has your child ever had	any serio	us illne	ess not listed above?	Yes	No	If yes, please explain	:				
											-
Comments:											-
											-
											•

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_