Date _____

Patient Registration & Medical History--Child

Thomas Schierbrock, DDS Andrea Cardenzana, DDS Caitlin Beresford, DDS

PATIENT INFORMATION

Name _____ Nickname_____ Birth date_____ Sex: M___ F___
Last First Init

Address_____ City_____ State_____ Zip_____ Home phone_____

Mother's name _____ Home phone_____ Cell phone_____ Work Phone _____

Address_____ Mother's employer _____

Father's name _____Home phone_____ Cell phone_____ Work Phone _____

Address_____ Father's employer_____

Names of siblings_____ School_____

In case of emergency who should be notified? _____ Phone_____

Whom may we thank for referring you? _____ Any other phone numbers we may need _____

Primary EMAIL address _____

PRIMARY DENTAL INSURANCE (NEED ALL INFORMATION ON POLICY HOLDER)

Person responsible for account _____ Relationship to Patient_____ Phone_____

Employer_____ Bus. Address & phone_____

Insurance Company _____ ID #_____

Group #_____ Subscriber #_____ Soc. Sec. #_____ Birth date _____

ADDITIONAL DENTAL INSURANCE (if patient is covered by additional insurance)

Subscriber name _____ Relationship to Patient_____ Phone _____

Employer_____ Insurance Company_____ ID #_____

Group #_____ Subscriber #_____ Soc. Sec. # _____ Birth date _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the above company (s) and assign directly to Dr. Schierbrock/Dr. Cardenzana/Dr. Beresford all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.
HIPAA: I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____ _____
Responsible Party Signature Relationship Date

Dental History (confidential)

Reason for today's visit? _____ Any discomfort at this time? _____

Previous dentist/location_____ How often does your child see a dentist? _____

Date of last dental care and cleaning._____ X-rays? ___Yes ___No When?_____

When does your child brush? ___After breakfast ___Before Bed _____ Other times? Does your child floss? _____

Does your child have sensitivity to:

Hot Cold Pressure Sweets Biting Eating/Chewing

Does your child have/use:

Battery toothbrush Water Jet Xylitol Gum Mouth Rinse Prescription Fluoride Sensitivity toothpaste

Bleaching Retainers Sports Mouth guard Night guard Maxillary/Mandibular Partials Mouth piercings

Has your child lost any teeth? YES / NO Why?_____ Complications with extractions? YES / NO _____

Does your child have bleeding gums? YES / NO FREQUENTLY / OCCASIONALLY / RARELY

Has your child had gum treatments? YES / NO When/where/why? _____

Has your child had their teeth straightened? YES / NO When/Where _____

Does your child grind or clench their teeth? YES /NO When? _____ Has this habit changed recently? YES / NO _____

Does your child have popping or clicking noises when they chew? YES / NO Does it cause discomfort? YES / NO _____

Has your child had treatment for TMJ problems? YES / NO Where/When? _____

Are you aware of any sores, swellings or lumps in your child's mouth? YES / NO _____

Does your child have frequent sinus infections? YES / NO Does your child have any other sinus problems? YES / NO

How much soda pop/sports drinks/bottled drinks/flavored water/energy drinks does your child drink a day and what kind? _____

_____ Has this habit changed recently? _____

Does your child have any fear of having dentistry done? YES / NO Why? _____

How do you and your child feel about their teeth? _____

Is it ok to have one of the other dentists in the practice for an exam if the usual dentist is not available? YES / NO

Patient's Name_____ date_____

Medical History (confidential)

Medical Doctor's name and location?_____phone_____

Date last seen by physician? _____ Does the child have any special needs_____

Has your child ever been hospitalized or had a major operation? _____

_____

Has your child ever had a serious head or neck injury? YES / NO If so, when? _____

Does your child use tobacco? Yes / No Has your child used or is using recreational drugs (confidential)? Yes / No

Women: ___Pregnant/trying to get pregnant ___Nursing ___Using a birth control medication

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

___Acid Reflux
___ADHD/ADD
___AIDS/HIV positive
___Anaphylaxis
___Anemia
___Anxiety
___Artificial Heart Valve*
___Artificial Joint*
___Asthma
___Autism
___Back problems
___Blood disease
___Blood Transfusion
___Breathing problems
___Cancer
___High Cholesterol
___Chemotherapy*
___Chemical Dependency
___Circulatory problems
___Cold sores
___Congenital Heart Disorder*
___Convulsions
___Cortisone Medications
___Coughing up blood
___Depression
___Diabetes
___Dialysis*
___Drug/Alcohol addiction
___Eating Disorder
___Excessive Bleeding/Bruising
___Epilepsy or Seizures
___Excessive thirst
___Fainting spells/Dizziness
___Frequent cough
___Frequent headaches
___Glaucoma
___Hay Fever
___Hearing problems
___Heart Murmur*
___Heart Pace Maker
___Heart Stent*
___Heart Trouble/Disease
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___Hives or Rash
___HPV
___ Hypoglycemia
___ Irregular Heartbeat
___ Jaundice
___ Kidney problems
___ Leukemia
___ Liver Disease
___ Low Blood Pressure
___ Lung Disease
___ Nervous problems
___ Parathyroid Disease
___ Psychiatric Care
___ Radiation Treatment
___ Mitral Valve Prolapse*
___Recent Weight Loss
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shingles
___Shortness of breath
___Sickle Cell Disease
___Special Needs
___Spina Bifida
___Shunt/Fusiport*
___Stomach/Intestinal Disease
___Swelling of Limbs
___Thyroid disease
___Tonsillitis
___Tuberculosis
___ Tumors or Growths
___Ulcers
___Vision problems

Has your child had any serious illnesses not listed above?_____

_____ _____ _____ _____

Have you ever been told that your child needs to take antibiotics before visiting a dentist? _____

PRE-MED Yes / No Why?_____ Pharmacy preferred_____

Anything else we should know about your child? _____

Medications

Prescription medications, pills, or drugs (Name, used for and dosage)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Over the counter medications, pills, or drugs

Aspirin Ibuprofen Tylenol Aleve (Naproxen)

Multi Vitamin Sinus Medication _____ _____

Does your child regularly take dietary supplements or herbal medicines? ____Yes ____No
If YES do you regularly take any of the following?

Diet or Energy supplements	Echinacea	Garlic	Ginger	Ginko	Ginseng
Horse Chestnut	St. John's Wort	Valerian	Vitamin E	Kava	Fish Oil >3g/day

Does your child regularly use any other natural or herbal health products? ____Yes ____No

Herbal/natural medications, pills, or treatments

_____ _____ _____ _____

Has your child had any side effects from herbs? ___Yes ___No Has your child recently stopped taking any herbs? ___Yes ___No
Has your child substituted herbs for prescription or over-the-counter drugs? ___Yes ___No

Allergies (please check any allergies the child might have)

____Aspirin ____Penicillin ____Codeine ____Sulfa ____Acrylic ____Metal ____Latex
____Local Anesthetics ____Food ____Environmental (dust, mold, pets)

Any other allergies_____

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 my child's health. It is my responsibility to inform the dental office on any changes in my child's medical status. I authorize the dental staff to perform any necessary dental treatment.

Signature of parent or guardian Date

Updates:
Date_____ Init ____ Date_____ Init ____ Date_____ Init ____ Date_____ Init ____ Date_____ Init ____

Date_____ Init ____ Date_____ Init ____ Date_____ Init ____ Date_____ Init ____ Date_____ Init ____