Date _____

Patient Registration & Medical History--Child

Caitlin Beresford, DDS Andrea Cardenzana, DDS Chad Menke, 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 _____

How do you prefer to be contacted for future appointments? EMAIL /TEXT/ PHONE CALL

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. Menke/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 AND MEDICAL HISTORY **(Confidential)**

Reason for today's visit? _____ Is this the first visit to a Dentist? ___Yes ___No

If not when was the last visit? _____ Has the patient ever had x-rays? ___Yes ___No When? _____

Have there been any of the following?
___Cavities ___Extracted teeth ___Toothaches ___Grinding teeth ___Gum Infection ___Straightened teeth

___Broken teeth ___Sensitive teeth Unhappy experiences? _____

Name of child's Medical Doctor_____ phone_____ Date of last physical exam_____

Is the child under the care of a Physician at this time? _____ Does the child have any special needs? _____

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_____

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 _____ _____

Is the child taking any herbal/natural medications, pills, or treatments? _____

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

___Acid Reflux	___Congenital Heart Disorder*	___Hemophilia	___Scarlet Fever
___AIDS/HIV positive	___Depression	___Hepatitis	___Sinus Trouble
___ADHD/ADD	___Diabetes	___Hives/Rash	___Special Needs
___Anemia	___Drug/Alcohol Addiction	___Hypoglycemia	___Spina Bifida
___Anxiety	___Eating Disorder	___Irregular Heartbeat	___Stomach /Intestinal Disease
___Asthma	___Epilepsy or Seizures	___Kidney Disease	___Thyroid disease
___Autism	___Excessive Bleeding/Bruising	___Liver Disease	___Tobacco habit
___Blood disease	___Fainting spells/Dizziness	___Psychiatric Care	___Tonsillitis
___Breathing problems	___Frequent headaches	___ Respiratory Disease	___Tuberculosis
___Cancer	___Heart Murmur*	___ Rheumatic Fever	___Tumors /Growths
___Cold sores/Fever Blisters	___Heart Trouble	___Mitral Valve Prolapse*	

Has the child had any serious illnesses not listed above? _____
Have you ever been told that the child needs to take antibiotics before visiting a dentist? _____
PRE-MED YES/ NO why? _____ Pharmacy preferred_____

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

Signature of parent or guardian Date