Welcome to **PEDIATRICS**

Patient Registration:

____

First Name Middle Last Name Nickname

Age____ Date of Birth________________ Male Female Phone (____)________________________________

Home Address: ____________________________________City_______________Zip________________

Child's School____Grade______________

First names of child's siblings: ____

Reason for visit:____

How did you hear about our office?____

Responsible Party:

Father/Guardian
Name_______________________________________
Married_________Single_________Divorced__________
Address (If different from patient's):
____
____
SS#_____________________Birth Date______________
Home phone (______)_____________________________
Work phone (______)_____________________________
Cell phone (______)_____________________________
Email Address_____________________________________
Employer____
Occupation_______________________________________

Mother/Guardian
Name_______________________________________
Married_________Single___________Divorced_________
Address (If different from patient's):
____
____
SS#_____________________Birth Date______________
Home phone (_______)____________________________
Work phone (_______)____________________________
Cell phone (_______)____________________________
Email Address_____________________________________
Employer____
Occupation_______________________________________

Emergency Contact Name_________________________________ Phone (_______)_________________________

Insurance:

Primary Dental Insurance___________________________
Group#____
Policy Holder Name______________________________

Secondary Dental Insurance_________________________
Group#____
Policy Holder Name______________________________

Loyal DENTISTRY

PEDIATRICS

Dental History:

Yes No

Is this your child's first visit to the dentist?

If no, name of previous dentist_____________________________Date of the last visit_________________

Does your child brush teeth daily?__________________________

Does your child floss daily?________________________________

Does your child receive fluoride supplements?________________

Any unhappy medical or dental visits? If yes, please explain:_____________________________________

____

Does your child have any of the following habits? Please circle all that apply;

Thumb/Finger Sucking/Pacifier Grinding Nail biting Mouth-Breating Nursing Bottle/Breast-feeding

Medical History:

Child's Pediatrician____________________________________City___________Phone (_____)___________________

Date of last physical examination_____________________Results____

Yes No

Is your child currently taking any medication?____

Has your child ever been hospitalized?______If so, reason____

Has your child ever had surgery?____

Is your child allergic to anything?____

Does your child require antibiotics for dental work because of a heart defect, heart murmur, prosthesis, shunt or other medical reasons?________________

Has your child ever had any of the following medical conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Abnormal Bleeding			Cleft Lip/Palate			Latex Allergy
		ADHD/ADD			Convulsion/Epilepsy			Premature Birth
		AIDS/HIV			Developmentally Delayed			Psychiatric Care/Counseling
		Anemia			Diabetes			Rheumatic Fever
		Artificial Joints/Heart Valves			Growth Problems			Sensory Disorder
		Asthma			Hearing Impairment			Skin Rash
		Autism			Heart Murmur/Defects			Syndrome_____________
		Brain Injury			Hemophilia			Tuberculosis
		Cancer/Chemotherapy/Radiation			Hepatitis			Other________________
		Cerebral Palsy			Kidney/Liver Disease			____________________

Do you wish to talk to the doctor privately about a special concern? Yes No

Consent:

I understand that the information that I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the office staff of Loyal Dentistry Pediatrics to perform the necessary dental services my child may need, using the appropriate materials and medicament. Parents/Legal guardians will be consulted before any treatment is started. The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Name of Parent or Legal Guardian____

Signature of Parent or Legal Guardian____Date__________________