CHILD REGISTRATION AND HISTORY

Needs to be completed by parents or legal guardian

Acct. #_____

Date_____

PERSONAL INFORMATION

X_____

Patient's Last Name First Middle Date of Birth

_____

Address City State Zip Home Phone

_____ _____ _____

Sex School Grade Social Security Number

WHO CAN WE THANK FOR REFERRING YOU? _____

Father's Name_____ Mother's Name _____

Father Employed By _____ Bus. Phone _____

Mother Employed By_____ Bus. Phone _____

Parent's Social Security # (Father's)_____/(Mother's) _____

Person Financially Responsible (If Other Than Parent)_____Relationship To Child _____

Address_____City_____State_____Zip_____Phone_____

INSURANCE INFORMATION

PRIMARY

Insurance Company

Name_____

Address_____

_____

ID#_____Group #_____

Date of Birth_____

SECONDARY

Insurance Company

Name _____

Address_____

_____

ID#_____Group#_____

AUTHORIZED AND ACCEPTANCE

I authorize the release of treatment information and hereby assign my insurance benefits to the doctor.

PLEASE COMPLETE THE REVERSE SIDE AND REVIEW

Date_____ Signature of Responsible Person_____

MEDICAL HISTORY (Please circle appropriate answer)

Do you or have you ever had:

Illness or surgery..... Yes No

Please list below
An allergic reaction..... Yes No
Hives, rash, hay fever..... Yes No

ANY REACTION TO:
Local anesthetics..... Yes No
Penicillin or antibiotics ..... Yes No
Sulfa drugs..... Yes No
Aspirin ..... Yes No
Iodine ..... Yes No
Codeine or other narcotics ..... Yes No
Latex ..... Yes No
Other ..... Yes No

Are you:
Taking any medication regularly **now** or within the past year?
(Please list below)..... Yes No

Are you:
Aware of a change in your general health in the past year..... Yes No
Presently being treated for any illness?
..... Yes No
Smoking?..... Yes No
Thyroid/Parathyroid disorders. Yes No
Herpes..... Yes No
Kidney disease..... Yes No
Hepatitis A or B or C..... Yes No
H.I.V..... Yes No
Liver disease..... Yes No
Alcoholism ..... Yes No
Diabetes..... Yes No
Epilepsy or seizures..... Yes No
Tuberculosis ..... Yes No
Asthma ..... Yes No
Emphysema ..... Yes No
Sinus trouble..... Yes No
Shortness of breath ..... Yes No
Prolonged bleeding..... Yes No
Arthritis ..... Yes No
Prosthetic joint..... Yes No
Date:_____
Venereal disease..... Yes No

Anemia..... Yes No
Prosthetic heart valve..... Yes No
High blood pressure..... Yes No
Extreme swollen ankles ..... Yes No
Stroke..... Yes No
Chest pains..... Yes No
Other Heart problems:
Heartburn or GERD ..... Yes No
Tumor/abnormal growth ..... Yes No
Radiation treament..... Yes No
Emotional problems or tension Yes No
Psychiatric treatment..... Yes No
Blood transfusion..... Yes No
Are you taking or have you ever taken Osteoporosis medications like Boniva, Fosamax, Actonel, Skelid, etc. (Bisphosphonates)..... Yes No
Chemotherapy..... Yes No
Do you snore, wake up multiple times at night, feel un-rested in the morning or have sleep apnea? ..... Yes No
If female, are you now:
Pregnant or trying to become pregnant?
..... Yes No
Taking oral contraceptives or hormonal therapy ..... Yes No

Date of last visit to MD:

Date of last Dental visit:

Date Surgeries

Name of physician _____Phone_____

Address_____City_____State_____ZipCode_____

I have completed the above health history and to the best of my knowledge have answered all questions correctly.

Signature_____Date_____

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date Addition

HIPPA ACKNOWLEDGEMENT

Patient acknowledgement
I have reviewed, understand, and agree to the content of the Notice of Privacy Practices.

Patient Signature_____Date_____