Patient Registration Paperwork

Patient Information:

Name:_____ Birth date:_____/_____/_____
Last *First* *MI*

Preferred Name: _____

SS#:_____ Age:_____

Gender: _____ Preferred pronouns: _____

School:_____ Grade:_____

Interests/Hobbies/Sports:_____

Address: _____
Street *Apt #*

_____
City *State* *Zip*

Phone #: (_____)_____-_____ Contact Email:_____

Name of person filling out this paperwork for patient: _____

Relationship to patient: _____

Are you the patient's legal guardian? _____Yes _____No

Guardian Information:

Primary Guardian's Name: _____
Last *First* *MI*

Relationship to Patient: _____

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Address *(If different from patient)*:_____
Street *Apt #*

_____
City *State* *Zip*

Guardian's SS#_____Birthdate: _____/____/_____ Phone Number: (____)_____-_____

Secondary Guardian's Name:_____
Last *First* *MI*

Relationship to Patient: _____

Address *(If different from patient)*:_____
Street *Apt #*

_____
City *State* *Zip*

Dental Insurance Information:

Primary Insurance:_____

Subscriber's Name: _____
Last *First* *MI*

Subscriber's Date of Birth: ____/____/_____

Group #:_____ Member ID: _____

Subscriber relationship to patient:_____

Subscriber's SS#_____

Employer:_____ How long employed_____

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Subscriber's Address:_____
Street *Apt #*

_____
City *State* *Zip*

(if applicable):

Secondary Insurance:_____

Subscriber's Name: _____
Last *First* *MI*

Subscriber's Date of Birth: ____/____/_____

Group #:_____ Member ID: _____

Subscriber relationship to patient:_____

Subscriber's SS#_____

Employer:_____ How long employed_____

Subscriber's Address:_____
Street *Apt #*

_____
City *State* *Zip*

Dental History:

Previous Dentist's Name:_____ Date of last dental visit:_____

Is the patient having any current dental/oral pain? _____No _____Yes

If yes, please explain: _____

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Has the patient experienced problems with previous dental work? _____No _____Yes

Has the patient ever experienced an injury to the mouth, teeth, or jaw? _____No _____Yes

Who brushes the patient's teeth? _____Patient _____Parent _____Patient and parent

Does the patient brush their teeth daily or have their teeth brushed daily? _____No _____Yes

Does the patient or parent floss the patient's teeth daily? _____No _____Yes

How often does the patient drink sugary liquids (juice, chocolate milk, sweet tea, sports drinks, soda, etc.)?_____

Does/Did the patient have braces/orthodontic treatment? _____No _____Yes

Does the patient have any dental anxiety? _____No _____Yes

If yes, please explain: _____

Does the parent have any dental anxiety? _____No _____Yes

Does/Did the patient have any of the following habits? (check boxes that apply to child)

- ☐ Clenching/grinding teeth
- ☐ Lip sucking/biting
- ☐ Nail biting
- ☐ Nursing Bottle habits
- ☐ Speech problems
- ☐ Thumb/Finger Sucking
- ☐ Any other oral habits? Explain _____

What is most important about the patient's relationship with Dr. Jackson? _____

_____

Is there a specific concern you would like Dr. Jackson to address about the patient's teeth or oral health at today's visit? _____

_____

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Medical History:

Name of patient's primary care physician:_____

Physician's Phone Number:_____

Physician's Address:_____
Street *Suite #*

_____
City *State* *Zip*

Is the patient currently under the care of a specialist? _____No _____Yes

If yes, for what conditions:_____

Is the patient taking any medication at this time? _____No _____Yes

If yes, list names of medications: _____

Does the patient have any drug allergies or has ever had an adverse reaction to any medication?
_____No _____Yes

If yes, list names of medications/drugs:_____

Has the patient ever responded adversely to medical treatment? _____

If yes, please explain: _____

_____

Is there anything else we should know about the patient's medical history? _____No _____Yes

If yes, please explain:_____

_____

_____

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Does the patient have or has the patient ever had any of the following:
(check all boxes that apply to the patient)

- ☐ AIDS/HIV
- ☐ ADD/ADHD
- ☐ Allergies to Anesthesia
- ☐ Allergies to Latex
- ☐ Allergies to Medications
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Epilepsy
- ☐ General Allergies
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Radiation Treatment
- ☐ Respiratory Treatment
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Tuberculosis (TB)
- ☐ Other: _____

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Does the patient have any special health care needs? _____Yes _____No

If yes, please explain: _____

_____

_____

OFFICE USE ONLY

I reviewed the medical/dental information of the patient named herein.

Doctor Signature:_____ Date _____

Patient ID _____

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OFFICE INFORMATION

Appointments:

Please understand that it is important for you to keep your child's scheduled dental appointments to maintain optimal dental health. Postponing treatment could compromise the child's condition resulting in discomfort and additional treatment.

The patient's appointment time is set-aside especially for the patient. We strive to stay on time and ask you to be on time for the scheduled appointment. We ask that if you have a change in your schedule and wish to change appointments, please contact our office 48 hours in advance so that we can schedule another appointment for the patient as soon as possible. Repeated cancellations or broken appointments without a 48 hour notice could result in a broken appointment charge or no reappointment.

Payment:

We realize that many families are in a state of change. The policy in our office is that the guardian who presents with the patient for treatment is responsible for payment.

Insurance:

We will file your claim as a courtesy at no charge. We will estimate a portion that insurance typically pays with the understanding that your plan could pay more or less. Any difference between our estimate and the amount actually paid is due from the patient/patient's guardian. We will inform you of this amount.

Patient Consent and Authorization:

I affirm that the above information I have given is correct to the best of my knowledge and will be used for treatment, billing, and processing of insurance claims. I will not hold my dentist or any staff members responsible for any omissions or errors that I may have made in the completion of this form. I understand that it is my responsibility to inform the office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary services that the patient may need. I assign the doctor all insurance benefits. I understand that I am responsible for all costs of dental treatment or any services rendered.

Guardian Signature:_____ Date:_____