McDonogh Dental Associates

CHILD PATIENT REGISTRATION

Date: _____

Name: _____ ◯ Male ◯ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Phone Number: _____ email: _____

Mother's information: ◯ Stepmother ◯ Guardian

Name: _____ Date of Birth: _____

Work Phone: _____ Home # _____ SSN: _____

Father's information: ◯ Stepfather ◯ Guardian

Name: _____ Date of Birth: _____

Work Phone: _____ Home # _____ SSN: _____

Party responsible for Payment: (credit bureau reports may be obtained)

Name: _____ Phone Number: _____ Relationship: _____

Address: _____

(signature of responsible party)_____

I am legally responsible for any charges and agree to payment of service charges and any unpaid balance over 60 days.

Dental Insurance (if applicable)

Group/Employer: _____ Group # _____

Insurance Company Name: _____ Phone Number: _____

Address: _____

Employee/Policy Holder: _____ Birthdate: _____ Subscriber ID: _____

I hereby authorize McDonogh Dental Associates to affix my signature (or spouse's) on my behalf as of this date and to extend two years hereafter. I authorize release of any informantion relating to this claim.

_____signature ◯ Parent ◯ Guardian

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

_____signature (insured person)

Dental Insurance (secondary)

Group/Emplyer: _____ Group # _____

Insurance Company Name _____ Phone Number: _____

Address _____

Employee/Policy Holder: _____ Birthdate: _____ Subscriber ID: _____

I hereby authorize McDonogh Dental Associates to affix my signature (or spouse's) on my behalf as of this date and to extend two years hereafter. I authorize release of any information relating to this claim.

_____signature ◯ Parent ◯ Guardian

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

_____signature ◯ Parent ◯ Guardian

Previous Dentist: _____ Date of last visit: _____

Whom may we thank for referring you? _____

Who is responsile for making appointments? Name: _____

Work Number: _____ Home Number: _____ Cell # _____

Why did you bring the child to the dentist today?

Has the child ever had a serious/difficult problem associated with previous work? ◯ Yes ◯ No

Is the child's water fluorinated? ◯ Yes ◯ No

Is the child taking fluoridated supplements? ◯ Yes ◯ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ◯ Yes ◯ No

Does the child brush his/her teeth daily ? ◯ Yes ◯ No

Floss his/her teeth daily? ◯ Yes ◯ No

Child's Physician: _____ Phone Number: _____

Date of last visit: _____

Is the child currently under the care of a physcian? ◯ Yes ◯ No

Please describe the child's current physical health: ◯ Good ◯ Fair ◯ Poor

Please List all the medications the child is currently taking.

Please List all the medications or materials the child is allergic to

Has the child ever had any of the following medical problems?

Bleeding disorder	◯ Yes	◯ No	Asthma	◯ Yes	◯ No
Handicaps/Disabilities	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No
Allergies to any drugs	◯ Yes	◯ No	Cancer	◯ Yes	◯ No
Hearing Impairment	◯ Yes	◯ No	HIV/AIDS	◯ Yes	◯ No
Any Hospital Stays	◯ Yes	◯ No	Congential Heart Defect	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Kidney/Liver Problem	◯ Yes	◯ No
Any Operations	◯ Yes	◯ No	Convulsions/Epilepsy	◯ Yes	◯ No
Developmental delay	◯ Yes	◯ No	Rheumatic/Scarlet Fever	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Tuberculosis (TB)	◯ Yes	◯ No

Please discuss any serious medical problems that the child has had:

Does the child have any of the following habits?

Lip sucking/biting	◯ Yes	◯ No
Nail biting	◯ Yes	◯ No
Nursing/bottle habits	◯ Yes	◯ No
Thumb/finger sucking	◯ Yes	◯ No

On behalf of my child, I hereby consent to dental care including but not limited to cleanings, fillings, or crowns. I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment and any additional treatment that the dentist considers necessary. I consent to the use of a local anesthetic and their potential risks. I have been given no assurances or guarantees as to the outcome of the treatment. I realize that in spite of the possible complications, the proposed treatment is necessary and desired by me. I understand that it is vital that I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures.

Signature_____ ◯ Parent ◯ Guardian

Date: _____