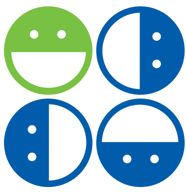

Patient Registration Form

Northwest Pediatric Dentistry

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Greenwood: 10241 Greenwood Ave N, Seattle, 98133 • 206.789.4035
Magnolia: 3203 W McGraw St, Seattle, 98199 • 206.708.7752
www.northwestpediatricdentistry.com

child's name ____ nickname ____ age ____ birth date __/__/__ gender ❑ M ❑ F

PARENT / GUARDIAN INFORMATION

name ____ birth date __/__/__
social security number ____
address ____
mobile phone ____ work phone ____
zip code ____
home phone ____ relationship to child ____
employer / occupation ____
email ____

PARENT / GUARDIAN INFORMATION

name ____ birth date __/__/__
social security number ____
address ____
mobile phone ____ work phone ____
zip code ____
home phone ____ relationship to child ____
employer / occupation ____
email ____

DENTAL INSURANCE

primary insurance subscriber name ____ birth date __/__/__
insurance carrier ____
group # ____ id# ____

secondary insurance subscriber name ____ birth date __/__/__
insurance carrier ____
group # ____ id# ____

MEDICAL HISTORY

heart disease ❑ Y ❑ N
heart murmur ❑ Y ❑ N
hearing / vision ❑ Y ❑ N
herpes / cold sores ❑ Y ❑ N
skin disorders ❑ Y ❑ N
diabetes ❑ Y ❑ N
seizures / epilepsy ❑ Y ❑ N
kidney / bladder ❑ Y ❑ N
hiv / aids ❑ Y ❑ N
developmental disorder(s) ❑ Y ❑ N
hepatitis / liver disease ❑ Y ❑ N
cancer ❑ Y ❑ N
asthma ❑ Y ❑ N

other____

allergies ____ latex sensitivity ❑ Y ❑ N

immunizations current ❑ Y ❑ N drug allergy ❑ Y ❑ N ____
If yes, please list allergies to drugs or meds

other medical conditions ____

current medications *(including fluoride supplement)* ____

pediatrician's name ____ pediatrician's contact info ____

Has your child ever had a negative medical or dental experience? ❑ Y ❑ N *If yes, please explain* ____

Is your child having dental problems or do you have specific concerns? ❑ Y ❑ N *If yes, please explain* ____

How would you describe your child (circle one)? SHY OUTGOING ANXIOUS

Additional comments / other ____

Is your child adopted? ❑ Y ❑ N

names & ages of siblings ____

pacifier / blanket ❑ Y ❑ N
nail biting ❑ Y ❑ N
nursing / bottle ❑ Y ❑ N
mouth breathing ❑ Y ❑ N
tongue thrusting ❑ Y ❑ N
thumb / finger sucking ❑ Y ❑ N
grinding / clenching ❑ Y ❑ N

other____

Do you drink well water, filtered water (i.e. Brita®) or bottled water? ❑ Y ❑ N

When are the child's teeth brushed (circle one): NEVER OCCASIONALLY 1X/DAY 2X/DAY MORE

When are the child's teeth flossed (circle one): NEVER OCCASIONALLY 1X/DAY 2X/DAY MORE

Who may we thank for referring you to our office? ____

Insurance claims are submitted as a courtesy for our patients. The parent/guardian who requests treatment for his or her child is responsible for all fees applied to the services rendered. A charge will be made for all cancellations with less than 24 hours notice.

I authorize the treatment of routine dental care and diagnostic records (including x-rays) for my child. I also agree to the use of local anesthetic and/or nitrous oxide which may be necessary or advisable by Dr. Johannsen and/or Dr. Marks for the comfort and well-being of my child.

I understand that I am financially responsible to the dentist(s) for payment in full within 30 days of treatment.

PARENT/GUARDIAN SIGNATURE ____ DATE __/__/__