Patient Registration Form

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Northwest Pediatric Dentistry

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www.northwestpediatricdentistry.com

child's name _____ nickname _____ age _____ birth date ___/___/___ ❑ M ❑ F gender

PARENT / GUARDIAN INFORMATION

name _____ birth date ___/___/___

address _____

zip code _____

employer / occupation _____

social security number _____

mobile phone _____ work phone _____

home phone _____ relationship to child _____

email _____

PARENT / GUARDIAN INFORMATION

name _____ birth date ___/___/___

address _____

zip code _____

employer / occupation _____

social security number _____

mobile phone _____ work phone _____

home phone _____ relationship to child _____

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 _____

_____

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 _____

_____

_____ latex sensitivity ❑ Y ❑ N

allergies

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

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. 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