Lake Dental Office - Dr. John and Dr. Deborah Lake

CHILD PATIENT REGISTRATION AND HEALTH HISTORY

Date:_____ Who referred you to our office?_____

PATIENT INFORMATION:

Name:_____ Birthdate:_____ Age:_____ ☐Male ☐Female

Home phone:_____ Work phone:_____ Cell phone:_____

Address:_____ City,State,Zip_____

Soc. Sec. No:_____ Marital Status:☐S☐M☐W Employer:_____

PARENT INFORMATION:

Mother:_____ Birthdate:_____ Age:_____

Soc. Sec. No:_____ Employer:_____

Cell phone:_____ Work phone:_____

Father:_____ Birthdate:_____ Age:_____

Soc. Sec. No:_____ Employer:_____

Cell phone:_____ Work phone:_____

EMERGENCY CONTACT INFORMATION: (person not living with you)

Name:_____ Phone no:_____

YOUR CHILD'S MEDICAL HISTORY:

ALLERGIES AND MEDICATION:

Is your child currently taking any medications? ☐ Yes ☐ No Please list all medications:_____

_____

Is your child allergic to any medications (such as Penicillin, Codiene, etc.)? ☐Yes ☐No Please list all allergies:_____

Is your child allergic to LATEX? ☐Yes☐No

PHYSICIAN AND MEDICAL CONDITIONS:

Your child's physician's name:_____ City_____

Has your child been under the care of a medical doctor or hospitalized during the past two years? ☐Yes ☐No

Reason? _____

Indicate which of the following conditions you have had or have presently. Please check Yes or No.

	Yes	No		Yes	No		Yes	No
Heart Condition	☐	☐	Artificial Joints	☐	☐	Psychiatric Disorders	☐	☐
Congenital Heart Disease	☐	☐	Kidney Problems	☐	☐	A.D.D. / A.D.H.D.	☐	☐
Heart Murmur	☐	☐	Ulcers	☐	☐	Developmentally Delayed	☐	☐
Mitral Valve Prolapse	☐	☐	Diabetes	☐	☐	Hepatitis Infection	☐	☐
Artificial Heart Valve	☐	☐	Thyroid Deficiency	☐	☐	Blood Transfusion	☐	☐
Rheumatic Fever	☐	☐	Glaucoma	☐	☐	Cold Sores/Fever Blisters	☐	☐
Hemophilia	☐	☐	Chronic Cough	☐	☐	Anemia	☐	☐
Arthritis	☐	☐	Tuberculosis	☐	☐	Bruise Easily	☐	☐
Cancer or Tumor	☐	☐	Asthma	☐	☐	Liver Disorders	☐	☐
Radiation/Chemo	☐	☐	Hay Fever	☐	☐	Epilepsy or Seizures	☐	☐
Liver Disorders	☐	☐	Sinus Infections	☐	☐	Fainting or Dizzy Spells	☐	☐

Do you have any other health concerns or problems not yet listed we should be aware of? ☐ Yes ☐ No

If yes, please explain:_____

FOR FEMALES ONLY: Is your child pregnant? ☐ Yes ☐ No If yes, what month? _____

Are they nursing? Yes☐ No☐ Are they taking birth control pills? ☐ Yes ☐ No

DENTAL HISTORY:

When was your child's last dental cleaning?_____ X-rays?_____
Treatment?_____
Has your child had orthodontic treatment? ☐ Yes ☐ No When?_____
Previous Dentist: _____ City:_____
Has your child had difficulty with previous dental visits? Yes ☐ No ☐ Explain:_____
_____
Does your child use a sippy cup or bottle for drinking? Yes ☐ No ☐
Does your child brush daily? Yes ☐ No ☐ Does your child floss daily? Yes ☐ No ☐
Does you child:

	Yes	No		Yes	No		Yes	No
Suck their thumb or finger	☐	☐	Snore	☐	☐	Bite or chew nails	☐	☐
Sleep restlessly	☐	☐	Grind teeth	☐	☐	Clench jaws	☐	☐

Have your child ever had their tonsils/adenoids removed? ☐ Yes ☐ No
Do you have or have you had any dental disease, condition or problem not listed? ☐ Yes ☐ No
If yes, please explain:_____

INSURANCE INFORMATION:

Primary Insurance: Insurance Company:_____
Insured:_____ Insured birthdate:_____
Insurance ID#:_____ Employer:_____
Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other
Secondary Insurance: Insurance Company:_____
Insured:_____ Insured birthdate:_____
Insurance ID#:_____ Employer:_____
Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Stepchild ☐ Other

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY:

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge. I authorize Doctor to perform necessary treatment for a thorough diagnosis of dental needs and treatment needed. Every effort is made to work with your insurance, but I understand financial responsibility for services performed on myself or dependents is mine and payment or estimated portion after insurance is due at time of service unless previously arrangements have been made. 1 ½ % monthly finance charge will be charged on all balances over 60 days.

Patient Signature:_____ **Date:**_____

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