

**DENTISTRY FOR SPECIAL PEOPLE, P.A.**

SINCERELY WELCOMES YOU TO OUR PRACTICE. LET'S GET ACQUAINTED.

**A LEGAL GUARDIAN MUST BE PRESENT FOR THE INITIAL TREATMENT PLANNING VISIT.**

(The better we know you and your child, the better we can help you both)

**REGISTRATION AND HEALTH HISTORY**

PLEASE PRINT

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex:  M  F

Patient's Age: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Names/Ages of other children: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

If parent of patient, parent's names:  \_\_\_\_\_

**MOTHER'S INFORMATION:**  Married  Divorced  Single May we contact you via e-mail?  Yes  No

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ E-mail: \_\_\_\_\_

**FATHER'S INFORMATION:**  Married  Divorced  Single May we contact you via e-mail?  Yes  No

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ E-mail: \_\_\_\_\_

***The Parent/Guardian accompanying the child is responsible for payment regardless of custody status.***

**PRIMARY DENTAL INSURANCE**

Insurance Company Name: \_\_\_\_\_

Insurance Company Address/Phone: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Orthodontic Coverage?  Yes  No

**SECONDARY DENTAL INSURANCE**

Insurance Company Name: \_\_\_\_\_

Insurance Company Address/Phone: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Orthodontic Coverage?  Yes  No

*Please be aware of your insurance coverage-What your deductibles, exclusions, and yearly maximums are.*

*If there are any questions, please check with your employer. Inform us immediately of any insurance changes.*

(Please continue on other side)

**PATIENT'S MEDICAL HISTORY**

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Group Name: \_\_\_\_\_

Address/City/State: \_\_\_\_\_

Allergic to any medicines, foods, pollen or substances etc.? List: \_\_\_\_\_

**DOES PATIENT HAVE OR HAD PREVIOUSLY ANY OF THE FOLLOWING MEDICAL PROBLEMS:**

Please explain any positive responses in the space provided below.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> ADHD                | <input type="checkbox"/> Communicable Diseases                            | <input type="checkbox"/> Heart, including murmurs                  | <input type="checkbox"/> Respiratory                             |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Current Medications                              | <input type="checkbox"/> Kidney                                    | <input type="checkbox"/> Rheumatic fever                         |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Digestive Disorders                              | <input type="checkbox"/> Liver/Hepatitis                           | <input type="checkbox"/> Speech                                  |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Drug or Alcohol Dependency                       | <input type="checkbox"/> Mental retardation                        | <input type="checkbox"/> Syndromes                               |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Epilepsy or seizures                             | <input type="checkbox"/> Mononucleosis                             | <input type="checkbox"/> Thyroid                                 |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Eye Problems                                     | <input type="checkbox"/> Previous Hospitalization                  | <input type="checkbox"/> Tuberculosis (T.B.)                     |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Family History of Reaction to General Anesthesia | <input type="checkbox"/> Previous Surgeries                        | <input type="checkbox"/> Other Problems not previously described |
| <input type="checkbox"/> Bladder             | <input type="checkbox"/> Females:   | <input type="checkbox"/> Psychiatric issues                        |  |
| <input type="checkbox"/> Bleeding Disorders  | Last menstrual  | <input type="checkbox"/> Reaction to Dental Anesthesia (Novocaine) |  |
| <input type="checkbox"/> Cancer              | period (If applicable)  | <input type="checkbox"/> Reaction to                               |  |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Hearing  | General Anesthesia   |  |
| <input type="checkbox"/> Cleft lip/palate    |   |  |  |

Response: \_\_\_\_\_

**DENTAL HISTORY**

First dental visit?  Yes  No      Name of Dentist: \_\_\_\_\_

Date last visit: \_\_\_\_\_ Exam \_\_\_\_\_ Cleaning \_\_\_\_\_ Fluoride \_\_\_\_\_ Treatment \_\_\_\_\_

Do you have any concerns for this visit? If so explain: \_\_\_\_\_

How would you describe the patients temperament? \_\_\_\_\_

Does the patient have a history of:

- Thumb Sucking     Tongue Thrust     Lip Sucking     Grinding Teeth     Finger Sucking     Lip Biting
- Mouth Breathing     Pacifier     Nail/Object Biting     Snoring/Sleep Apnea     Drug or Alcohol Dependency

Has there ever been any injury to any of the teeth or the mouth? \_\_\_\_\_

Are there any dental problems you are aware of? \_\_\_\_\_

For children under 5 years of age, at what age was the child weaned from the bottle or breast? \_\_\_\_\_

**ACKNOWLEDGEMENT AND AUTHORITY**

I hereby certify the above health history is accurate and true and that the dentist is relying on the accuracy to render care.

Because \_\_\_\_\_ is a minor, it becomes necessary that signed or verbal permission is obtained from a parent or guardian before any and/or all necessary dental services recommended can rendered.

I will only authorize any procedure to be performed for my child after I am satisfied that I've been given all the reasonable information that I want.

I also acknowledge full responsibility for the payment of such services and agree to pay for them in full AT THE TIME OF SERVICE, unless other arrangements are made with the Administrative Department of this office.

May we request release of any of your child's medical (including psychological) records for our reference?  Yes  No

May we take photographs for educational purposes?  Yes  No

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_