PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

Date _____ Date of Birth _____

PARENT'S NAME _____

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RESIDENCE _____ BUSINESS _____

PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO WILL PAY THIS ACCOUNT _____

PURPOSE OF CALL _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

Mom's SS#
Dad's SS#

INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYER _____ #YRS _____

NAME OF INSURANCE CO. _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NUMBER _____

INSURANCE 2ND COVERAGE

_____

_____ # YRS _____

_____

_____

_____

_____

MEDICAL HISTORY	YES	NO
Is child now in poor health		
Is child under care of physician		
Name of physician		
Has child had surgery		
Is surgery contemplated		
Is child subject to profuse bleeding		
Is child subject to nervous disorders		
fainting		
dizziness		
Is child allergic to penicillin		
or other drugs		
Is child receiving any medication		
Has child had history of diabetes		
heart trouble		
asthma		
kidney infection		
rheumatic fever		
toothache		

DENTAL HISTORY	YES	NO
Is this the child's first visit to a dentist		
If not, how long since his last visit to the dentist		
Does child eat between meals		
Does child eat sweets, such as candy		
soda pop, chewing gum		
Does child eat a well balanced diet		
Does child brush teeth upon arising		
when going to bed		
right after eating meals		
after eating any food		
Do you have fluoridated water in the home		
Have teeth been treated with fluorides		
Have any cavities been noted in the past		
Were any teeth (baby or permanent) removed		
by extraction		
Was it suggested that the space be maintained		
Was appliance placed		
Have there been any injuries to teeth — falls, blows, chips, etc.		
Has child had any unfavorable dental experience		
How many children in your family		
Has child been recommended for othodontics		
Has child received a local anesthetic		

Parent's signature _____

D-323

REGISTRATION FORM

MED. ALERT