CHILD REGISTRATION AND HEALTH HISTORY

Please Complete the Following Confidential Information

PATIENT INFORMATION

LAST NAME:______________________________ FIRST NAME:____________________ M.I.:_____

NICKNAME:______________________________ DATE OF BIRTH:____________________ SEX:______________

FATHER'S NAME______________________________ MOTHER'S NAME______________________________

HOME ADDRESS: ______________________________ CITY:________________ ST:_____ ZIP:__________

HOME PHONE:______________________________ CELL PHONE:______________________________

WHO MAY WE THANK FOR YOUR REFERRAL TO OUR CLINIC:______________________________

RESPONSIBLE PARTY

LAST NAME:______________________________ TITLE:__________ FIRST NAME:____________________ M.I.:____

HOME ADDRESS: ______________________________ CITY:________________ ST:_____ ZIP:__________

DATE OF BIRTH:______________________________ SS#:________ - ________ - __________ SEX:______________

HOME PHONE:____________________ WORK PHONE:____________________ CELL PHONE:____________________

EMPLOYER: ______________________________

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME:______________________________ EMPLOYEE OR ID#:____________________

RELATION TO PATIENT:________________ SS#:________ - ________ - __________ DOB:____________________

EMPLOYER NAME:______________________________ GROUP#: ____________________

INSURANCE COMPANY NAME & ADDRESS:______________________________

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME:______________________________ EMPLOYEE OR ID#:____________________

RELATION TO PATIENT:________________ SS#:________ - ________ - __________ DOB:____________________

EMPLOYER NAME:______________________________ GROUP#: ____________________

INSURANCE COMPANY NAME & ADDRESS:______________________________

The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% finance charge (12% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note. I hereby authorize payment of the dental benefits otherwise payable to me directly to Stone & Johnson Dental Group.

RESPONSIBLE PARTY FOR PATIENT:

SIGNATURE:______________________________ DATE:____________________

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DENTAL HISTORY

Are you happy with your smile?_________ If you could change anything about your smile, what would it be? ______________________

____

How often do you brush? ______________ Brush is Soft _ Medium _ Hard _ How often do you floss? ______________

Please check all of the following that apply to you:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Sore gums
- ☐ Clicking or popping jaw
- ☐ Jaw pain
- ☐ Change in bite
- ☐ Burning tongue/ lips
- ☐ Grinding teeth
- ☐ Clenching teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Biting cheeks/lips
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitive when biting
- ☐ Food collection between teeth

Have you ever been treated for periodontal disease, gum disease, pyorrhea, trench mouth? ☐ Yes ☐ No

If yes, when? ____

MEDICAL HISTORY

Has there been any change in your general health within the past year? ______________________

Family Physician ______________________________________Date of last visit ______________________

Are you currently being treated by a physician? ☐ Yes ☐ No If yes, what condition? ______________________

Have you been a patient in the hospital in the past two years? ☐ Yes ☐ No If yes, what condition were you treated for? __________

Have you had any surgeries in the past year? ☐ Yes ☐ No If yes, please explain______________________

Please list all medications you are currently taking: ______________________________________

____

____

Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ______________________

If yes, please list: ____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you ever had any of the following:

HEART or CIRCULATORY

- Yes No Angina
- Yes No Artificial Heart Valves
- Yes No Bleeding Abnormally
- Yes No Blood Disease
- Yes No Blood Transfusion
- Yes No Bruise Easily
- Yes No Circulatory Problems
- Yes No Congenital Heart Lesions
- Yes No Heart Attack / Disease
- Yes No Heart Failure
- Yes No Heart Murmur
- Yes No Hemophilia
- Yes No High Blood Pressure
- Yes No Mitral Valve Prolapse
- Yes No Pacemaker
- Yes No Rheumatic Fever
- Yes No Scarlet Fever
- Yes No Shortness of Breath
- Yes No Stents
- Yes No Stroke
- Yes No Swelling of Feet or Ankles
- Yes No Heart Surgery
  Describe__________________
- Yes No Heart Problems Other
  Describe__________________

RESPIRATORY:

- Yes No Asthma
- Yes No Cough, Persistent
- Yes No Emphysema
- Yes No Respiratory Problems
- Yes No Sinus Trouble
- Yes No Tuberculosis

SKELETAL:

- Yes No Arthritis/Rheumatism
- Yes No Artificial Joints
  Date ____________________
- Yes No Back Problems

GENERAL

- Yes No Allergies or hives
- Yes No Skin Rash
- Yes No Hay Fever
- Yes No Cancer
- Yes No Chemotherapy
- Yes No Radiation Treatment
- Yes No Kidney Disease
- Yes No Liver Disease/Hepatitis/Yellow Jaundice
- Yes No Anemia
- Yes No Chemical Dependency
  Describe__________________

- Yes No Cold Sores
- Yes No Cortisone Medication/Treatment
- Yes No Cosmetic Surgery
- Yes No Diabetes (circle) Type I or II
- Yes No Epilepsy/Seizure
- Yes No Fainting or Dizzy Spells
- Yes No Glaucoma
- Yes No Headaches
- Yes No Nervous Problems
- Yes No Psychiatric Care
- Yes No Sickle Cell Disease
- Yes No HIV+ / AIDS
- Yes No Thyroid Problems
- Yes No Ulcer
- Yes No Venereal Disease

Do you have any disease, condition or problem not listed? ______________________________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative______________________________Date________________