



# Minor Patient Registration

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

Childs Last Name: \_\_\_\_\_ Childs First Name: \_\_\_\_\_ MI \_\_\_\_\_

Parent's Marital Status:      Single       Married       Divorced       Widowed

Parent's Legal Guardian's Names: \_\_\_\_\_  
\_\_\_\_\_

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

Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Childs Date of Birth: \_\_\_\_\_ Parent's Email: \_\_\_\_\_

Childs Age: \_\_\_\_\_ Male       Female

Primary Insurance Policy Holder: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Member/Subscriber ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance Policy Holder: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Member/Subscriber ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**How were you referred to this office?**

- Friend or Family (Name): \_\_\_\_\_
- Community Event       Yellow Pages       Facebook       Walk in       Mailer
- Internet site: \_\_\_\_\_       Referred by Dr. \_\_\_\_\_
- Other \_\_\_\_\_

**How will today's services be taken care of?**

- Cash       Check       Credit Card (MC / Visa / Discover / American Express / Care Credit )

**Dental History:** \_\_\_\_\_

**Have you ever had, or currently have, any of the following conditions?**

- |                         |                              |                             |                             |                              |                             |
|-------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|
| Bleeding Gums           | <input type="checkbox"/> yes | <input type="checkbox"/> no | Clench / Grind Teeth        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Tender or Swollen gums  | <input type="checkbox"/> yes | <input type="checkbox"/> no | Unusual dental experiences  | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Loose Teeth             | <input type="checkbox"/> yes | <input type="checkbox"/> no | Orthodontic Treatment       | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Sensitive Teeth         | <input type="checkbox"/> yes | <input type="checkbox"/> no | Periodontal (gum) Treatment | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Any other sore areas    | <input type="checkbox"/> yes | <input type="checkbox"/> no | Root Canal Treatment        | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Any injury to the mouth | <input type="checkbox"/> yes | <input type="checkbox"/> no | Crown or Bridge Treatment   | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Do you ever have clicking, popping, or discomfort in the jaw joints?  yes  no

Do you have headaches, earaches, or neck pains?  yes  no

Are you unhappy with the appearance of your teeth?  yes  no

**Is there anything else about your dental history we should know?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have any questions or concerns?**

\_\_\_\_\_

**What is the name of your medical doctor?** \_\_\_\_\_

Are you currently under medical treatment?       yes       no

If yes, please explain :

Have you been hospitalized within the past three years?  yes  no

Why? \_\_\_\_\_

Do you have any allergies or adverse reactions to drugs?  yes  no

Please list: \_\_\_\_\_

Are you taking any medications, pills, drugs, or herbal supplements?  yes  no

Please list: \_\_\_\_\_

Have you ever taken Bisphosphonates, such as Fosamax, Actonel, Aredia, Boniva, or Zometa?  yes  no

Do you currently use any form of tobacco?  yes  no

What form? \_\_\_\_\_ How much? \_\_\_\_\_

Are you interested in quitting?  yes  no

Women (Please mark)

Are you:  Pregnant  Nursing  On Hormone Therapy  Using Birth Control  N/A

Has a Physician ever informed you that you have or have had any of the following conditions?

(please check box)

Heart Trouble	<input type="checkbox"/> yes	<input type="checkbox"/> no	Ulcers	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart Murmur	<input type="checkbox"/> yes	<input type="checkbox"/> no	Acid Reflux	<input type="checkbox"/> yes	<input type="checkbox"/> no
Rheumatic Fever	<input type="checkbox"/> yes	<input type="checkbox"/> no	Osteoporosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Congenital Heart Defect	<input type="checkbox"/> yes	<input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
Artificial Heart Valve	<input type="checkbox"/> yes	<input type="checkbox"/> no	Bruise Easily	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> no	Sinus Trouble	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no
History of bacterial endocarditis	<input type="checkbox"/> yes	<input type="checkbox"/> no	Kidney Trouble	<input type="checkbox"/> yes	<input type="checkbox"/> no
Chest Pain	<input type="checkbox"/> yes	<input type="checkbox"/> no	Liver Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	Hepatitis (any form)	<input type="checkbox"/> yes	<input type="checkbox"/> no
Low Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	Nervousness	<input type="checkbox"/> yes	<input type="checkbox"/> no
Blood Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	Psychiatric Care	<input type="checkbox"/> yes	<input type="checkbox"/> no

<b>Anemia</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>AIDS / HIV</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Bleeding Problems</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Venereal Disease</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Asthma</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Arthritis / Gout</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Shortness of Breath</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Rheumatism</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Emphysema</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Frequent Headaches</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Lung Disease</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Auto-immune disorder</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Fainting or Dizziness</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Thyroid Disorder</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Stroke</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Seizures</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Diabetes</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Tobacco use</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Artificial Joints/Hips</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	<b>Drug Use / Addiction</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no
<b>Any other serious illness or health problem not mentioned above?</b>			<input type="checkbox"/> yes	<input type="checkbox"/> no	

**Please describe:**

---



---

**Do you wish to speak to the doctor privately about any problem?** \_\_\_\_\_

**I certify that the above information is complete and accurate.**

**Signature of Patient, Parent or Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_