Children's Registration Form (please fill in completely)

Name_____Preferred name_____Date_____
Address_____City_____State_____Zip_____
Home Phone_____Cell Phone_____
Okay to text appt. time/date?_____if so, cell phone carrier?_____
Birthdate____/____/____/ Sex: M F
Father's Name_____Father's Social Security #_____
Father's Employer_____Position_____Bus. Phone_____
Mother's Name_____Mother's Social Security #_____
Mother's Employer_____Position_____Bus. Phone_____
Name of emergency contact_____Phone_____

Health Information When was your last dental appointment?_____

Is child under care of physician? Yes No
If so, for what_____
Is child taking medication? Yes No
If so, what_____
Has child ever been hospitalized? Yes No
If so, what_____
Has child ever had surgery? Yes No
If so, what_____
Allergy to any drugs, latex, metals? Yes No
If so, to what_____

Tonsils or adenoids been removed? Yes No
Has patient reached puberty? Yes No
If so, what age_____
Does or has child sucked thumb or fingers? Yes No
If so, until what age_____
Is patient a mouth breather while awake? Yes No
Is patient a mouth breather while asleep? Yes No
Have orthodontic appliances been worn? Yes No
Any missing teeth? Yes No
Any extra permanent teeth? Yes No
Any unhappy dental experiences? Yes No
If so, what_____

Does patient have or ever had: (please circle)

Anemia Asthma Heart Ailments
Cerebral palsy Chicken pox Convulsions
Diabetes Epilepsy Fainting Hearing Loss
Hepatitis Kidney problems Liver problems
Measles Mononucleosis Mumps
T.B. Rheumatic Fever Cold Sores

Any emotional problems? Yes No
If so, what?_____
Any speech problems? Yes No

How often does child brush teeth?
_____
Do you assist child with brushing? Yes No
Is dental floss used? Yes No
How is child's attitude towards dentistry?
_____
_____

I certify that the information above is correct. I am responsible for this account and understand that payment for all services is due upon treatment. There will be a service charge of 1.5% monthly-18% annually on accounts past due.

Signature_____Date_____

Insurance Information

Insurance Company Name & Address_____

_____

Insured Name & Address_____

_____

Insurance ID or SS #_____Group #_____

Insured Employer_____Insured Birthdate_____

Patient name_____Patient Birthdate_____

Relationship to insured____self____child____spouse___other____Patient sex___M___F

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to Dr.Johnson of the group insurance otherwise payable to me.

Signature_____

Is patient covered by another dental insurance plan____Yes____No if yes, please continue

Insurance Company Name &Address:_____

_____

Insured name & address_____

_____

Insured ID or SS #_____ Group #_____

Insured employer_____Insured Birthdate_____

HIPPA

We are required by law to maintain the privacy of your Protected Health Information. No information will be disclosed without written/oral authorization, except as described in the Notice. Our office has posted the notice Notice of Privacy Practices for your to review. I have been informed of the above law.

Signature_____

Record Release Form

Release records to_____

Signature_____Date_____