Dependent Registration

Child's Name _____Preferred Name_____ Date of Birth ____/____/____
Address_____ City_____ State____ ZIP_____

With whom does the patient reside_____ Male ☐ Female ☐

Soc Sec #_____-_____-_____ Home Phone_____ Cell Phone_____

Person Financially responsible for account _____ Relationship to Patient _____

Email_____How did you hear about our practice_____

Father/Guardian Name___ _____ Address if different:_____ _____ Soc Sec # _____-_____-_____ Employer_____ Occupation_____ Date of Birth_____ Phone Number_____	Mother/Guardian Name___ _____ Address if different:_____ _____ Soc Sec # _____-_____-_____ Employer_____ Occupation_____ Date of Birth_____ Phone Number_____

Primary Dental Insurance

Policy holder's name_____D.O.B._____Soc Sec#_____-_____-_____
Group Name/Employer_____ID #_____Group #_____
Insurance Company_____Insurance phone number_____
Policy holder's relationship_____

Secondary Dental Insurance

Policy holder's name_____D.O.B._____Soc Sec#_____-_____-_____
Group Name/Employer_____ID #_____Group #_____
Insurance Company_____Insurance phone number_____
Policy holder's relationship_____

Health History

Has the child ever had any of the following conditions **(please circle)**

Allergy to Antibiotics	Cancer	Hearing/Speech Impairment	Kidney/Liver Disease
Allergy to Dyes	Cerebral Palsy	Heart Condition	Pacemaker
Allergy to Latex	Convulsions/Epilepsy	Heart Murmur	Respiratory Disease
Allergy to Medications	Developmental Delay	Hemophilia/Blood Disorders	Sinus Problems
Asthma	Diabetes	Hepatitis	Thyroid Disease
Autism	Handicaps/Disabilities	HIV/AIDS	Tuberculosis

If **NONE** are circled please initial here_____Premedication Y ☐ N ☐ if yes, please list _____
Please list all **Medications** the child is currently taking_____
Please list the child's **Allergies**_____
Other_____
Child's Physician_____Phone Number_____

*********OVER*********

Dental History

Does the child have any of the following habits? **(please circle)**

Lip Sucking/Biting	Nail Biting	Thumb/Finger Sucking
Grind Teeth	Clench Jaws	Nursing/Bottle Habits

If **NONE** are circled please initial here_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No Dosage_____Type_____

Does the child brush his/her teeth daily? Yes No

Does the child floss daily? Yes No

Soda/Sugary Drinks Y ☐ N ☐ if yes, how often?_____

Favorite Snacks_____

Custody

Patient's primary custody: Father ☐ Mother ☐ Both ☐ Does patient have foster parents: Yes ☐ No ☐

Name of Patient's Legal Guardians_____

Address if different_____

Emergency Contacts

In event of Emergency, whom may we contact other then yourself?

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

All information gathered is for the sole purpose of insurance verification and billing. All personal information which Locust Lane Dental requests is held in the strictest confidence.

To the best of my knowledge, I have answered every question completely and accurately.

Parent/Guardian Signature_____Date_____

Medical History Update

Date_____Signature_____Staff Intials_____

Comments_____

Date_____Signature_____Staff Intials_____

Comments_____

Date_____Signature_____Staff Intials_____

Comments_____

*********OVER*********