Castellano and Carpenter Dental Associates PC

PATIENT REGISTRATION

PATIENT INFORMATION

Full Name______________________________ Preferred Name________________________________

Address __________________________ City__________________ State________ Zip__________

Home Phone _________________ Birth Date ________________ Age _______ Sex M____ F ____

SS# _______ - ______ - _______ Email Address____

RESPONSIBLE PARTY INFORMATION

Will be contacted for appointment reminders

Full Name______________________________ Relationship to Patient__________________________

Address __________________________ City__________________ State________ Zip_______

Home Phone _________________ Work Phone________________ Cell Phone __________________

Birth Date ________________ Sex M ____ F ____ Email Address ______________________________

SS#______ - _____ -________ DL# _______________________________

Place of employment ____________________ Occupation ______________________________

Spouse name: ___________________________ Occupation ______________________________

INSURANCE INFORMATION

☐ Check if NO DENTAL INSURANCE ☐ Check if MEDICAID

Insured Full Name______________________________ Relationship to Patient __________________

Address __________________________ City__________________ State________ Zip_________

Home Phone _________________ Work Phone ________________ Cell Phone __________________

Birth Date _____________________ Sex M _____ F _____ SS# _______-______-________

Employer ________________________________ Insurance Name ______________________________

Policy # _________________ Group # __________________ Insurance Ph # ____________________

Claims Address ________________________ City _________________ State ________ Zip_________

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OTHER FAMILY MEMBERS WHO COME TO PRACTICE

Name ____________________ Birth Date ______________ Relationship ______________

Name ____________________ Birth Date ______________ Relationship ______________

Name ____________________ Birth Date ______________ Relationship ______________

Name ____________________ Birth Date ______________ Relationship ______________

OTHER INFORMATION

Emergency Contact ________________

Emergency Phone # ________________

Relationship to Patient ______________

Preferred Pharmacy ________________

Pharmacy Phone # _________________

How did you hear about our office?

REFERRED BY (check one):

- ☐ Doctor/ Dentist ______________
- ☐ Friend ________________
- ☐ Office Staff______________
- ☐ School/Daycare______________
- ☐ Phone Book ______________
- ☐ Website ________________
- ☐ Other __________________

IS THERE ANY SPECIFIC QUESTION/TOPIC YOU WOULD LIKE TO MAKE SURE WE ADDRESS WHILE YOU AND YOUR CHILD VISIT US?

____

____

____

____

____

____

____

As a courtesy, a claim will be filed to your primary insurance.

*The *estimated* patient portion is due when services are rendered. *

Patient Name ______________________________ **DOB** ____________________________________

For the following questions, please check the appropriate answer and fill out the necessary information. Your answers are for our records only as they help us provide you with a more thorough visit and will be considered strictly confidential.

PHYSICIAN/PEDIATRICIAN INFORMATION

Pediatrician/Physician Name ______________________ Address ____________________________

Phone # ____________________________ Fax # ____________________________

Please list other specialists your child may be seeing:

1.___________________________ Address _______________________ Phone # ________________

2. ___________________________ Address _______________________ Phone # ________________

Date of last regular check-up:___________ Date of last medical visit:__________ Reason:___________

FAMILY/SIBLING HISTORY

Are you aware of any hereditary medical conditions from the parental side? __ Yes __ No __ Don't know

If yes, please explain ____

Are you aware of any hereditary medical conditions from the maternal side? __ Yes __ No __ Don't know

If yes, please explain____

MEDICAL NARRATIVE

Is your child:

Under the care of a doctor at the present time? __ NO __ Yes When? ________ Why?___________

Taking any medications at the present time? __ NO __ Yes What? __________________

Allergic to any medications? __ NO __ Yes What? __________________

Allergic to any foods, materials or dyes? __ NO __ Yes What? __________________

Has your child:

Had general anesthesia? __ NO __ Yes

Had any complications with general anesthesia? __ NO __ Yes Explain? ____________________

Had any surgeries? __ NO __ Yes When? ________ Why?___________

Ever been a patient at the Emergency Room? __ NO __ Yes When? ________ Why?___________

Ever been hospitalized as a patient? __ NO __ Yes When? ________ Why?___________

__ HIV+AIDS
__ Anemia/Sickle Cell Trait
__ Allergy/Hay Fever
__ Arthritis/Rheumatism
__ Artificial Heart Valve
__ Artificial Joint or Limb
__ Asthma
__ Attention Deficit Disorder (ADD/ ADHD)
__ Autism
__ Behavior Learning Disabilities
__ Problem Learning?
__ Problem Concentrating
__ Problem Understanding
__ Bleeding Disorder
__ Birth Defects
__ Bone/Joint Orthopedic Problems
__ Brain Surgery
__ Cancer-type:__________
__ Chemotherapy/Radiation
__ Cerebral Palsy
__ Chicken Pox
__ Cleft Lip/Palate
__ Convulsions/Seizures
__ Diabetes
__ Digestive Disturbances
__ Earaches
__ Emotional Disturbances
__ Epilepsy
__ Eye Problems
__ Fainting
__ Glandular Disturbance
__ Hearing Loss/Aids/Implants
__ Heart Problem/Surgery
__ Hemophilia
__ Hepatitis __A, __B, __ C
__ High/Low Blood Pressure
__ Hormonal Disturbance
__ Hydrocephalus
__ Kidney Problems
__ Leukemia
__ Liver Problems
__ Malignant Hypothermia
__ Measles
__ Mental Retardation
__ Mumps
__ Mouth Ulcers
__ Nutritional Disturbances
__ Polio
__ Pregnancy
__ Rheumatic Fever
__ Scarlet Fever
__ Scoliosis
__ Shuts (VA, W, VP)
__ Speech Problems
__ Surgeries
__ Syndrome:____
__ Tetanus
__ Tuberculosis
__ Venereal Disease
__ Whooping Cough
__ Pneumonia
__ Organ Transplant
__ Heart Murmur

Does your child have any other disease, condition or medical problems not mentioned above? ___ No ___Yes

Please List:____

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

Signed ________________________ Relationship to child _______________ Date ___________________

MEDICAL INFORMATION

Patient Name ______________________________ DOB ______________________

For the following questions, please check the appropriate answer and fill out the necessary information. Your answers are for our records only as they help us provide you with a more thorough visit and will be considered strictly confidential.

DENTAL INFORMATION

What is the reason for your child's first visit to our dental office?

__ Consultation __ Emergency __Preventative/Exam __ Other

Parent level of apprehension? __ High __ Medium __ Low __ None

Name of previous dentist ________________ Telephone ______________

May we contact previous dentist for records and X-rays? __ Y __ N

Have your child ever had an injury to the teeth, lips, tongue or chin in the past? __ Y __ N

Dietary Facts

Does your child snack between meals? __Y __ N

Number of snacks? _____

Does patient eat a balanced diet? __ Y __ N

Does your child take a bottle/Sippy cup at bedtime or naptime __ Y __ N

At what age was bottle/nursing stopped? __ yrs __ mo

Please list your child's favorite snacks:

1.__________________ 2.__________________

3.__________________ 4.__________________

5.__________________ 6.__________________

7.__________________ 8.__________________

FLUORIDE & TOOTH BRUSHING

Is your child taking fluoride supplements presently? __Y __N If Yes, what form?__________

Has your child received fluoride supplements in the past? __ Y __ N

Does your child use fluoride toothpaste? __Y__ N

Brushing frequency?__ 1x daily am__ 1x daily pm __2x daily __ After each meal/snack

What type of toothbrush does your child use? __ Regular __ Electric __ Cloth __ Other

Dental flossing frequency? __ Use daily __ Occasionally __ Never

Who is responsible for tooth brushing? __ Parent __ Child __ Both

HABIT ASSESMENT

Please check if any of the following habits exist or existed and answer all that apply:

Sucking History __ Still __ Past thumb/finger habit stopped at __yrs __ Never had thumb/finger habit

Was or is the habit done? ___ Day & Night ___ Night only ___ When tired or sleepy

Grinding Teeth History ___ Still ___ Past grinding habit-stopped at __ yrs ___Never had grinding habit

Was or is the habit done? ___ Day & Night ___ Night only ___ When tired or sleepy

Other Habits? ___ Nail biting ___ Lip biting ___ Cheek and/or tongue biting ___ Mouth breathing

Does your child snore? ___ Yes ___ No

DENTAL INFORMATION

Castellano and Carpenter Dental Associates PC

Authorization For Minor Child

Childs's Full Name:________________________ DOB:____________

I,________________________________, give____________________________________
(Parent or Legal Guardian) (Authorized Person Full Name)

permission to accompany my child to the office of Castellano and Carpenter Dental Associates for dental appointments. I also give permission to ____________________
(Authorized Person Full Name)

to make any necessary decisions regarding dental treatment for my child, including but not limited to:

- **The consent for this authorized person to sign any and all forms required to give permission to Castellano and Carpenter Dental Associates to treat the dental needs of my child,**
- **The consent to the dental practice to discuss finances (treatment charges, account, balances, next visit charges) with this authorized person,**
- **The consent to the dental practice to discuss my child's future dental treatment needs, (i.e. treatment plans),**
- **The consent for this authorized person to sign my child's treatment plan once it has been presented by the dental staff. I understand this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of my child,**
- **The consent for this authorized person to schedule future dental visits for my child.**

I understand this consent will be valid for one year or until I resign this agreement in writing.

_________________________________ **___________________**
Signature of parent or Legal Guardian **Date**

_________________________________ **___________________**
Castellano and Carpenter Dental Associates **Date**