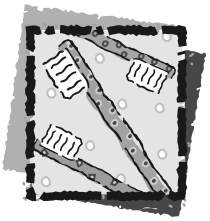

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Patient Registration Form

Tell us about your child

Child's Name:_____ Preferred Name: _____ Male O Female O
Child's Age: _____ Child's D.O.B.:_____ School:_____ Grade:_____
Child's Home Address:_____
Child's Home Phone:_____ S.S.N._____
Siblings that we treat:_____

Who is accompanying the Child Today?

Name:_____ Relation:_____ Do you have legal custody of the child? Yes O No O
In case of emergency, contact (name & phone #)_____
Whom may we thank for this referral:_____

Parent/Guardian Information

Mother/Guardian
Name:_____ D.O.B._____
Address:_____

Employer:_____
Occupation:_____
S.S.N._____
Driver's License#:_____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
E-mail Address:_____
Marital Status:_____

Father/Guardian
Name:_____ D.O.B._____
Address:_____

Employer:_____
Occupation:_____
S.S.N._____
Driver's License#:_____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
E-mail Address:_____
Marital Status:_____

Dental Insurance Information

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone:_____ Group#or Plan, Local or Policy #:_____
Insured's Name:_____ Relationship to child:_____
Insured's D.O.B._____S.S.N:_____ Insured's Employer:_____

Dental History

Has your child ever suffered from any of the following dental related problems?

Yes	No		Yes	No	
O	O	Speech Problems	O	O	Popping or Soreness of the Jaws (Right, Left or Both)
O	O	Grinding or Bruxing Habit	O	O	Previous Dental Infection or Abscess
O	O	Stained or Discolored Teeth	O	O	Pain from Teeth Where? _____
O	O	Cold Sores or Fever Blisters	O	O	Past Injury or Trauma to Teeth, Mouth, Lips or Face

Has your child been prescribed fluoride supplements/use fluoridated toothpaste? O Yes O No If yes, please explain._____
Does your child brush their teeth two times a day? O Yes O No If so, do you assist? O Yes O No
Does your child suck a thumb, finger, pacifier or blanket? O Yes O No
How would you predict your child's behavior to be today? O Cooperative O Nervous O Defiant O Don't Know
Has your child ever been treated by a dentist? O Yes O No A pediatric dentist? O Yes O No If so, who?_____
Previous dentist's phone number:_____
When was your child's last dental visit? _____ Were radiographs taken at this visit? O Yes O No O Don't Know

What are your primary concerns regarding your child's oral health?

_____

_____

(Continued on the following page)

Dental History

Has your child ever had any of the following conditions?

Yes	No		Yes	No	
O	O	Sickle Cell Anemia or Trait (when? _____)	O	O	Measles, Mumps, or Chicken Pox
O	O	Bleeding Disorder or Hemophilia	O	O	Malignant hyperthermia
O	O	Tonsillectomy and/or Adenoidectomy (when? _____)	O	O	Skin Disorder or Eczema _____
O	O	Bruises or Bleeds Easily	O	O	Hepatitis (Type ____)
O	O	Anemia or Blood Disorders	O	O	Chronic Ear Infections / Otitis Media
O	O	Heart Murmur (Innocent or Pathological)	O	O	Tuberculosis or Positive Test Result (when? _____)
O	O	Immunologic Disorder, HIV, AIDS or ARC	O	O	Stomach or GI Disorder _____
O	O	Heart Condition_____	O	O	Is parent or patient pregnant?
O	O	Hypertension or Hypotension	O	O	Appendectomy (when? _____)
O	O	Rheumatic Fever/Scarlet Fever	O	O	Seasonal Allergies, Hay Fever, etc.
O	O	Cystic Fibrosis	O	O	Diabetes Mellitus (NIDDM or IDDM_____ x day)
O	O	Asthma or Lung Problems (Inhaler, Nebulizer)	O	O	Febrile Seizure, Fainting Spells
O	O	Thyroid Disorder	O	O	Frequent Headaches
O	O	Cancer, Lymphoma or Leukemia _____	O	O	Premature Birth (Weeks Early ____)
O	O	Seizure Disorder, Epilepsy (Last Episode _____)	O	O	Diagnosed with ADD, ADHD or Hyperactivity
O	O	Blood Transfusions	O	O	Cleft Lip and/or Palate (Bilateral, Unilateral) (Right, Left)
O	O	Learning Disability (Mild, Moderate, Severe)	O	O	Congenital Birth Defects/Syndrome _____
O	O	Autistic (Mild, Moderate, Severe)	O	O	Cerebral Palsy, Muscular Dystrophy
O	O	Neurological Disorder, Hydrocephaly	O	O	Kidney Disease or Transplantation
O	O	Delayed Development, MR (Approx age child functions____)	O	O	Handicaps or Disabilities _____
O	O	Liver Disease or Transplantation_____	O	O	Hospital Stays or Significant Injuries _____
			O	O	Is child's immunization record current?

Comments (Office Use Only):

Please list all medications patient is currently taking _____

Yes	No	
O	O	Is your child allergic or ever had an adverse reaction to a medication? If so, which?_____
O	O	Does your child have an allergy to latex, foods or dyes? If so, which?_____

Other Medical Conditions Not Noted Above: _____

Please list the names & phone numbers of any physicians that are currently treating your child.

Type of Physician:_____ Doctor's Name_____ Office Phone Number_____
Type of Physician:_____ Doctor's Name_____ Office Phone Number_____
Type of Physician:_____ Doctor's Name_____ Office Phone Number_____

Consent and Authorization

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Dr. Michael P. Marfori and staff specific consent to do an oral exam, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions, if deemed necessary. I understand I will be consulted before any treatment is rendered.

I authorize the insurance company indicated on this form to pay Dr. Marfori all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Marfori to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Parent/Guardian Signature Date

SUBMIT