

# AUSTIN CHILDRENS DENTISTRY - PATIENT REGISTRATION

To help us meet all of your child's dental needs, please fill out the front and back of this form completely and accurately

## PATIENT INFORMATION:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  F  M  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home telephone #: \_\_\_\_\_ Other #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Do we see siblings?  No  Yes If yes, please list their names: \_\_\_\_\_  
Whom may we thank for referring you to our office?  Insurance Website  Insurance Directory  Friend  
 Relative  Phone Book  Walk in  Other \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

**Father**  Stepfather  Guardian  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
Home telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_  
 **Mother**  Stepmother  Guardian  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
Home telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

## INSURANCE

As a **courtesy**, we will accept assignment of benefits from most insurance companies. In order to do so, you must provide us with the following information:

Do you have dental insurance?  Yes  No Would you like us to bill your insurance company?  Yes  No  
Name of person insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Insured's SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Group Name (employer): \_\_\_\_\_ Group #: \_\_\_\_\_  
Claims mailing address: \_\_\_\_\_

## DENTAL HISTORY

Why is your child here today? \_\_\_\_\_  
Is this your child's first visit to the dentist?  Yes  No If no, date of last visit: \_\_\_\_\_  
Will your child be a cooperative patient? \_\_\_\_\_  
Please describe how you think your child will behave today. Check all that apply:  
 Friendly  Happy  Anxious  Timid  Afraid  Resistant  
Does or did your child receive fluoride in any form?  Yes  No Please describe: \_\_\_\_\_  
Has your child inherited any dental characteristics? \_\_\_\_\_  
Have there been any injuries to your child's teeth? \_\_\_\_\_

Place a check in the box below if your child has or had any of the following problems:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cavities              | <input type="checkbox"/> Toothache           | <input type="checkbox"/> Bad breath       |
| <input type="checkbox"/> Crooked teeth         | <input type="checkbox"/> Sensitive to sweets | <input type="checkbox"/> Bleeding gums    |
| <input type="checkbox"/> Sensitive to hot/cold | <input type="checkbox"/> Frequent headaches  | <input type="checkbox"/> Discolored teeth |
| <input type="checkbox"/> Loose teeth           | <input type="checkbox"/> Teeth bumped        |   |

Does your child have any of the following oral habits?

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Lip biting  | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Pacifier use  | <input type="checkbox"/> Other _____ |   |

How often does your child brush his/her teeth? \_\_\_\_\_

Does your child floss his/her teeth?  Yes  No

At what age did your child stop using the: Bottle? \_\_\_\_\_ Sippy cup? \_\_\_\_\_

## MEDICAL HISTORY

Child's physician: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Is your child in good general health?  Yes  No

If no, please describe: \_\_\_\_\_

Were there any problems at birth?  Yes  No

If yes, please describe: \_\_\_\_\_

Are your child's immunizations and booster shots up to date?  Yes  No

Has your child ever been allergic to anything?  Yes  No

What was the drug/food and type of reaction? \_\_\_\_\_

Has your child had any surgical operations?  Yes  No

If yes, what? \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No

If yes, for what? \_\_\_\_\_

### Has your child had or does he/she now have?

Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Eating disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroid therapy or chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous or mental disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth defects <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps, measles or chickenpox <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Cleft lip or palate <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer, tumors, growths or cysts <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems or drainage <input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS virus <input type="checkbox"/> Yes <input type="checkbox"/> No	High fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis or TB exposure <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	High or low <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with anesthesia <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear, eye, nose or <input type="checkbox"/> Yes <input type="checkbox"/> No	blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No
nose trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stomach ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice or hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	

### CURRENT MEDICATIONS"

Name / Strength (mg)	How often?	Reason taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor's comments:

## SOCIAL HISTORY

Does your child have problems with any of the following?  Speech  hearing  vision  sleep

Do you consider your child to be?  Advanced learning  Progressing normally  A slow learner

Child's first language? \_\_\_\_\_ Second language? \_\_\_\_\_

Is your child adopted?  Yes  No If yes, what age? \_\_\_\_\_

Child's favorites (pet, toy, color, friend, hobby, etc.) \_\_\_\_\_

How does your child tolerate dental/medical care? \_\_\_\_\_

### Authorization and Release:

*I understand that payment of a calculated % is due at the time treatment is rendered, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that any unpaid balances may be sent to a collection company and that the debtor is responsible for all collection charges. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me.*

*To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers' and/or other health practitioners.*

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_