alexandria braces

Child Registration History

We are pleased you have chosen us to provide your oral health care. Be assured that our staff of professionals is current on all techniques of dentistry and are committed to providing you with the highest quality dental care in the most gentle, efficient and enthusiastic manner possible.

Sex: ___ Male ___ Female

Child's name: _____ Nickname:_____ Age:____

Address:_____Zip Code:_____Birth Date:_____

Cell Phone:_____ School:_____

Father's Name:_____Employer:_____

Father's Address:_____ Cell Phone:_____Carrier:_____

Mother's Name:_____ Employer:_____

Mother's Address:_____Cell Phone:_____Carrier:_____

Email Address:_____

Father's S.S.#:_____Mother's S.S.#:_____

In Case of an Emergency, Who should be notified?_____

Whom may we thank for referring you to our office?_____

Person responsible for payment of account:_____Cell Phone:_____

What is Child's Favorite: Sport_____Toy_____ Hobby_____

Person_____ Fictional Character:_____Food:_____

Names and Ages of other children in the family:_____

Date of Last Dental Visit:_____Purpose of Last Dental Visit:_____

Date of Last Routine Cleaning:_____Dentist Name:_____

Dentist 's Phone Number:_____Dentist Address:_____

Purpose for Today's Visit:_____

What is/are your main concern(s) about the condition of your child's teeth:

_____

What would you like to see in your child's dental practitioner?

_____

As a legal guardian or parent for a minor, I verify that the responses listed above are true and complete. I have read and fully understand the office policy.

_____ _____

(signature) (date)

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Child Medical and Dental History

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical and dental history form. This information is, of course, confidential.

Child's First Name:_____Child's Last Name:_____

Child's Date of Birth:_____Phone Number:_____Today's Date:_____

If you are completing this form for another person, what is your relationship to that person?

Your Name:_____Relationship:_____

Medical History

Current Pediatrician:_____

Pediatrician's Phone Number:_____Date of last visit:_____

Your child's current physical health is: Good Fair Poor

Is your child's currently taking any medications? Y N

If yes, please list here:_____

Has your child ever had any of the following medical problems?

Abnormal Bleeding	Y	N	Handicaps/Disabilities	Y	N
Artificial Bones/Joints	Y	N	Hearing impairment	Y	N
Arthritis	Y	N	Heart Problems	Y	N
Asthma	Y	N	Hepatitis	Y	N
Blood Pressure Problems	Y	N	Heart Surgery	Y	N
Blood Transfusions	Y	N	HIV+/AIDS	Y	N
Cancer/Chemo/Radiation	Y	N	Kidney/Liver defects	Y	N
Cerebral Palsy	Y	N	Physical Growth Problems	Y	N
Chicken Pox	Y	N	Mitral Valve Prolapse	Y	N
Chest Pains	Y	N	Skin Problems	Y	N
Convulsions/Epilepsy/Seizures	Y	N	Psychiatric Treatment	Y	N
Diabetes	Y	N	Rheumatic/Scarlet Fever	Y	N
Difficulty Breathing	Y	N	Shingles	Y	N
Stomach Problems	Y	N			
Fainting Spells	Y	N	Sinus Problems	Y	N
Fever Blisters/Cold Sores	Y	N	Tuberculosis	Y	N
Sickle Cell Disease	Y	N	Migraine	Y	N
Thyroid Problems	Y	N	Anemia	Y	N
Learning, Behavioral, Communication Problems				Y	N

Has your child been hospitalized? If yes, please state why:

_____

For Female Patients:	Are you taking birth control pills?	Y N
	Any problems with menstrual cycle?	Y N
	Practicing birth control with oral contraceptives?	Y N

Is your child allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N
Any metals	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Erythromycin	Y	N

Other:_____

For Adolescent Patients:	Any recreational drug use?	Y N
	Tobacco Use?	Y N
	Any Alcohol use?	Y N
	Medication for Diet Control	Y N

Dental History

How many months has it been since your child's last dental check-up?_____

Have your child ever had a negative dental experience? Y N

Your child's current dental health is: Good Fair Poor

Does your child like his/her smile? Y N

Does your child's gums ever bleed? Y N

Has your child been evaluated or had orthodontic treatment? Y N

Has your child ever injured their face, mouth, teeth, or chin? Y N

Has your child's adenoids or tonsils been removed? Y N

Does your child have any missing, extra, or impacted teeth? Y N

Has your child ever had any pain or tenderness in your jaw joint (TMJ/TMD)? Y N

Does your child take any prescriptions or OTC drugs? Y N

If yes, please list each one:_____
_____
_____

Has your child ever taken bisphosphonate drugs (Fosamax, Boniva, etc. used to treat osteoporosis or multiple myeloma)?
Y N

Please elaborate on any dental or orthodontic concerns and any additional medical concerns:
_____
_____

I hereby state that the information on this form is true and is correct to the best of my knowledge I understand the above information is necessary to provide me with dental care in a safe and efficient manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication

Signature:_____ Date:_____
(parent or legal guardian)

Orthodontist Signature:_____Date:_____

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Dental Insurance Subscriber Information

(1) PRIMARY SUBSCRIBER INFORMATION If there is no dental insurance, skip to box (3)	
Name:	
Relationship to Patient:	
Address:	
City:	
State, Zip:	
Home Phone:	
Work Phone:	
Cell Phone:	
Birth Date: / /	Sex: M F
Social Security #:	
Employer:	
(2) DENTAL INSURANCE INFORMATION	
Insurance Name:	
Ins. Address:	
Ins. Phone #:	
Group #:	
Member ID #:	
PATIENT INFORMATION	
Name:	Birth Date: / /
(3) RESPONSIBLE PARTY Circle one: MR MRS MS MISS DR Check here if information is the same as the insurance subscriber ___Primary or ___Secondary	
Name:	Home Phone: Cell:
Relationship to Patient:	Work Phone: Email:
Address:	Birth Date: / / Sex: M F
City:	Social Security #:
State, Zip:	Employer:

Your insurance policy is a contract between you and your insurance company. Please familiarize yourself with your insurance benefits, deductibles, annual maximums and lifetime benefits. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If a secondary insurance applies, it will be the patients responsibility to file to that insurance in the event we are a non-participating provider with that plan.

Payment is due at the time of service. Please note there will be a fee for all returned checks. In the event an account balance becomes delinquent and is forced into collections, the patient agrees to pay all cost incurred. Dental, including, but not limited to, court costs and attorney fees. As the patient (or parent of a minor) I verify that the responses listed above are true and complete. I have read and fully understand the office policy.

Any missed appointments without 48 hours notice will result in a $75 charge to the patient. These charges are due and payable within 30 days.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

RESPONSIBLE PARTY SIGNATURE:_____

DATE:_____ STAFF INITIALS:_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices. I have the right to receive a copy upon request.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____
_____
_____
_____
_____
_____

Received By: _____
(Signature of Staff Member)