Welcome to Power Road Dental Care

Child Registration

Patient_____
First Middle Last
Sex: M___F___ Birthdate_____ Age_____ Social Security #_____

Mother's name_____ Father's name_____
Address_____ Address_____
_____ _____
Home Ph #_____ Home Ph #_____
Cell Ph #_____ Cell Ph #_____
Employer_____ Employer_____
Work Ph #_____ Work Ph #_____

Who does this child live with?_____
What is the purpose of this appointment?_____
When and where was the child's last dental visit?_____
Names of brother's and sisters_____

Primary Dental Insurance Information

Subscriber's name_____
Subscriber's address_____
Subscriber's SS#_____ Birthdate_____
Relationship to patient_____
Subscriber's employer_____
Business address and phone_____
Insurance Company_____ Phone #_____
ID#_____ Group #_____

Secondary Dental Insurance Information

Subscriber's name_____
Subscriber's address_____
Subscriber's SS#_____ Birthdate_____
Relationship to patient_____
Subscriber's employer_____
Business address and phone_____
Insurance Company_____ Phone #_____
ID#_____ Group #_____

In case of an emergency who should be notified? Please give name and phone number.

Relative_____
Non-Relative_____

Health History

Is the child under a physician's care? Yes No
If so, what for?_____
Has the child been hospitalized in the last 5 years? Yes No
If so, what for?_____

Indicate which of the following the child has had or has at present. Circle "yes" or "no" to each item.

Heart Murmur	Yes	No	Lung Problems	Yes	No
Heart Problems	Yes	No	Rheumatic fever/heart	Yes	No
Liver Problems	Yes	No	Kidney Problems	Yes	No
Circulatory Problems	Yes	No	Nervous Problems	Yes	No
Bleeding Problems	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Diabetes	Yes	No
Thyroid	Yes	No	Cancer	Yes	No
Artificial valves,limbs,joints	Yes	No	Asthma	Yes	No
Implants	Yes	No	TB	Yes	No
Allergies/Hayfever	Yes	No	Sinus Problems	Yes	No
Hives	Yes	No	Ulcers	Yes	No
Chicken Pox	Yes	No	Measles	Yes	No
Mumps	Yes	No	Mononucleosis	Yes	No
Cold Sores	Yes	No	Pink Eye	Yes	No
Daily Fluoride Tablets	Yes	No	HIV/AIDS	Yes	No
Attention deficit Disorder	Yes	No			

List all allergies_____
(Penicillin, Codeine, Latex, Any Metals)
Has the child ever had any adverse reactions to local anesthetic? Yes No
Epinephrine? Yes No
List all medications, including vitamins and herbal supplements that the child takes
_____
Is there anything else you want us to know?_____
_____

Authorization Release

I certify that I have read and answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health and that it is my responsibility to inform this office in any changes in their medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care, to third party payers and/or health practitioners. I hereby give my consent for any preventative and/or restorative treatment that the dentist and I have deemed necessary. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____
Date_____