



Patient Registration Form

Patient's name: _____ Date of birth: ___/___/___ Male / Female

Mother's name: _____ Date of Birth: ___/___/___ SS#: _____

Mother's Employer: _____ Email: _____

Mother's Cell Phone: _____ Other Phone: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Father's Name: _____ Date of Birth: _____ SS# _____

Father's Employer: _____ Cell Phone: _____

INSURANCE

Primary Insurance Company: _____

Subscriber : _____ Employer: _____

Subscriber # or SS#: _____ Group #: _____

Insurance Phone Number: _____

Secondary Insurance Company: _____

Subscriber # or SS#: _____ Group #: _____

Insurance Phone Number: _____

Insurance is a contract between you and your insurance company. We bill your insurance company as a courtesy to you, but note that payment is due at time of service. Although we estimate your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You must agree to pay any portion of the charges not covered by the insurance.

I hereby authorize payment by my dental insurance company be directly paid to Smiles 4 Kids. I also authorize the release of any dental information necessary to process dental claims. At the discretion of the office, we may use the services of one or more credit reporting services. I acknowledge receipt of the notice of privacy practices.

Parent/Guardian Signature: _____ Date: _____



Dental History

Child's Name: _____ Date of Birth: ____/____/____ Male Female

How did you hear about us? _____

Does your child have an unusual history of the following:

- Nursing/Bottle Habits Pacifier Thumb/Finger Sucking Dental Grinding

MEDICAL HISTORY

Name of Child's Physician: _____ Phone: _____

Is Child taking any medications? Yes No If yes, what? _____

Is Child allergic to any of the following medications or substances? Yes No

- Aspirin Penicillin Latex Foods Metal/Acrylics Other: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

AIDS/HIV <input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy <input type="checkbox"/> YES <input type="checkbox"/> NO	Growth Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Orthopedic Problems <input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Chemotherapy <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Murmur/Heart Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Tobacco Use <input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma/Breathing Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Child Abuse <input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis/Liver Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Pregnancy <input type="checkbox"/> YES <input type="checkbox"/> NO
Autism <input type="checkbox"/> YES <input type="checkbox"/> NO	Chronic Adenoid/Tonsil Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO	Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO
Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO	Cleft Lip/Palate <input type="checkbox"/> YES <input type="checkbox"/> NO	Bladder Conditions <input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO
ADHD <input type="checkbox"/> YES <input type="checkbox"/> NO	Developmentally Delayed <input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Disease <input type="checkbox"/> YES <input type="checkbox"/> NO	Disabilities/Special Need <input type="checkbox"/> YES <input type="checkbox"/> NO
Birth Defects <input type="checkbox"/> YES <input type="checkbox"/> NO	Drug/Alcohol Use <input type="checkbox"/> YES <input type="checkbox"/> NO	Leukemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Speech/Hearing Problems <input type="checkbox"/> YES <input type="checkbox"/> NO
Brain Injury <input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional Disturbance <input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO	Convulsions/Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO
Bruise Easily <input type="checkbox"/> YES <input type="checkbox"/> NO	Excessive Gagging <input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO	Tumors/Growth <input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding/Clotting Problems <input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting/Dizziness <input type="checkbox"/> YES <input type="checkbox"/> NO	Prosthetic Joints/Pins <input type="checkbox"/> YES <input type="checkbox"/> NO	Psychiatric Care <input type="checkbox"/> YES <input type="checkbox"/> NO
Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO	Fever Blisters <input type="checkbox"/> YES <input type="checkbox"/> NO		

If answered "YES" to any of the above, please explain: _____

Parent/Guardian: _____ Date: _____

Doctor: _____ Date: _____

Parent/Guardian: _____ Date: _____ (1)

Doctor: _____ Date: _____

Parent/Guardian: _____ Date: _____ (2)

Doctor: _____ Date: _____