DENZINGER
FAMILY DENTISTRY

Welcome!

Child

PATIENT INFORMATION **PLEASE PRINT**

CHILD REGISTRATION

DATE: _____

FULL NAME: _____

HOME PHONE: _____

NICKNAME: _____

WORK PHONE (Guardian): _____

STREET ADDRESS: _____

CELL PHONE (Guardian): _____

CITY/STATE/ZIP: _____

EMAIL (Guardian): _____

GENDER: M / F MARITAL STATUS S M D

CHILD'S SSN#: _____

WHOM MAY WE THANK FOR YOUR REFERRAL?: _____

CHILD'S DOB: _____

GUARDIAN INFORMATION & PERMISSION FOR DENTAL TREATMENT OF MINOR CHILD

MOTHER/GUARDIAN FULL NAME: _____ DOB: _____ SSN: _____

FATHER/GUARDIAN FULL NAME: _____ DOB: _____ SSN: _____

PERSON(S) FINANCIALLY RESPONSIBLE: _____ RELATION: _____

EMERGENCY CONTACT: _____ / TYPE OF RELATION: _____ PHONE: _____

I, _____ the parent/legal guardian of _____ who is a minor, do hereby authorize and consent to any x-rays, examination, anesthetic, dental treatment rendered under the direct or indirect supervision of DENZINGER FAMILY DENTISTRY as they may deem necessary. This authorization will remain in effect until cancelled in writing.

HEALTH INFORMATION

PHYSICIAN'S NAME: _____ PHONE: _____

IS YOUR CHILD CURRENTLY UNDER A PHYSICIAN'S CARE Y / N (Please circle one) EVER HOSPITALIZED? Y / N (Please circle one)

REASON(S): _____

CURRENT MEDICATIONS: _____

ANY SPECIAL NEEDS? _____ (Females only: Taking birth control? Y / N)

PRIMARY INSURANCE INFORMATION

EMPLOYED BY: _____

WORK PHONE: _____

DENTAL INSURANCE CO: _____

INS. CO. PHONE: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDERS SSN# _____

GROUP NUMBER: _____

POLICY HOLDERS DOB: _____

POLICY ID NUMBER: _____

RELATION TO POLICY HOLDER: _____

SECONDARY INSURANCE INFORMATION

EMPLOYED BY: _____

WORK PHONE: _____

DENTAL INSURANCE CO: _____

INS. CO. PHONE: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDERS SSN# _____

GROUP NUMBER: _____

POLICY HOLDERS DOB: _____

POLICY ID NUMBER: _____

RELATION TO POLICY HOLDER: _____

DOES YOUR CHILD HAVE OR HAVE THEY HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO TO EACH.

Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?"
These include combinations of Lonimim, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ Yes ❑ No

Angina	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Arthritis / Rheumatism	❑ Yes ❑ No	HIV / Aids	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Immune Deficiency	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Bleeding Abnormally,		Autoimmune Disorder	❑ Yes ❑ No	Tumor / Malignancy	❑ Yes ❑ No
with extractions or surgery	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Bleeding Problems/Blood Thinners	❑ Yes ❑ No	Joint Replacement : Hip / Knee	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Kidney Disease/Problems	❑ Yes ❑ No		
Chemical Dependency	❑ Yes ❑ No	Liver Problems	❑ Yes ❑ No	**DENTAL HISTORY**	
Chemotherapy	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Bad Breath	❑ Yes ❑ No
Cigarette / Pipe / Cigar / Dip	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Bleeding Gums	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Blisters on Lips or Mouth	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Organ Transplant	❑ Yes ❑ No	Broken Fillings	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Clenching of Teeth	❑ Yes ❑ No
Cough, persistent or bloody	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Clicking or Popping Jaw	❑ Yes ❑ No
Defibrillator/Pacemaker	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No	Dry Mouth	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Respiratory Problems	❑ Yes ❑ No	Grinding of Teeth	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	Gums Swollen or Tender	❑ Yes ❑ No
Epilepsy / Seizures	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No	Jaw Pain / Jaw Tiredness	❑ Yes ❑ No
Fainting or Dizziness	❑ Yes ❑ No	Shunt Placed	❑ Yes ❑ No	Lip or Cheek Biting	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No	Loose Teeth	❑ Yes ❑ No
Headaches (____ x per month)	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No	Mouth Breathing	❑ Yes ❑ No
Heart Attack (year:_____)	❑ Yes ❑ No	Stroke (year:_____)	❑ Yes ❑ No	Sensitivity to Cold / Heat / Sweets	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Swollen Feet / Ankles / Neck Glands	❑ Yes ❑ No	Sores or Growth in their Mouth	❑ Yes ❑ No
Heart Valve / Replacement Stent	❑ Yes ❑ No	Taking Blood Thinner Medications	❑ Yes ❑ No		
Hepatitis A / B / C	❑ Yes ❑ No	Taking Insulin	❑ Yes ❑ No		
Herpes	❑ Yes ❑ No	Taking Medication for Osteoporosis	❑ Yes ❑ No		

FEMALES:

Is your child pregnant? ❑ Yes ❑ No Due Date _____
Taking birth control pills? ❑ Yes ❑ No

MEDICATIONS

List any medications your child is currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin
❑ Barbituates (Sleeping Pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

UPDATES (to be filled in at future appointments)

Has there been any change in your child's health since their last dental appointment? ❑ Yes ❑ No
For what condition? _____

Is your child taking any new medications? ❑ Yes ❑ No If so, what? _____

_____

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

Has there been any change in your child's health since their last dental appointment? ❑ Yes ❑ No
For what condition? _____

Is your child taking any new medications? ❑ Yes ❑ No If so, what? _____

_____

_____

Signature of Patient, Parent, Guardian or Personal Representative Date