

MT. AIRY CHILDREN'S DENTAL ASSOCIATES

Specialists in Pediatric Oral Health Care and Orthodontics for Children and Adults

Patient Information	
Name: _____	
FIRST	MI
LAST	
Nickname: _____	Gender: M / F
Birthdate: _____	Age: _____
School/Home school _____	Grade: _____
Home Address: _____	
Home Phone: _____	
List the Preferred Telephone # for Appointment Confirmation: _____	
Hobbies/Sports: _____	
List Siblings: _____	

Person Financially Responsible for Account	
Name: _____	
FIRST	MI
LAST	
Relationship to Patient: _____	
Birthdate: _____	SSN: _____
Billing Address: _____	
Home Phone: _____	
Work Phone: _____	
Cell Phone: _____	
Email Address: _____	

Mother's Information: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	
Name: _____	
FIRST	MI
LAST	
Birthdate: _____	SSN: _____
Home Address: _____	
Home Phone: _____	
Work Phone: _____	
Cell Phone: _____	
Email Address: _____	
Employer: _____	
Employer Address: _____	

Father's Information: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	
Name: _____	
FIRST	MI
LAST	
Birthdate: _____	SSN: _____
Home Address: _____	
Home Phone: _____	
Work Phone: _____	
Cell Phone: _____	
Email Address: _____	
Employer: _____	
Employer Address: _____	

Who is Accompanying Your Child Today?	
Name: _____	Relation: _____
Do you have legal custody of this child? <input type="radio"/> YES <input type="radio"/> NO	
Whom may we thank for referring you? _____	
<input type="radio"/> Dentist <input type="radio"/> Physician <input type="radio"/> Insurance <input type="radio"/> Friend <input type="radio"/> Advertisement <input type="radio"/> Phone Book	
Neighbor or Relative not living with you: Name, Relationship & Phone: _____	

Primary Dental Insurance <i>(Please provide a copy of dental insurance card)</i>	
Insurance Co. Name: _____	
Insurance Co. Phone #: _____	
Policy Owner's Name: _____	
Policy Owner's Birthdate: _____	SSN/ID#: _____
Relation to Patient: _____	
Policy Owner's Employer: _____	
Employer's Phone: _____	

Parent/Guardian Signature		
Parent/ Guardian Initials	 _____	I acknowledge that I was offered/provided a copy of the Notice of Privacy Practices and I have read or had the opportunity to read and understand the notice. One Notice of Privacy Practices shall apply to all patients within the same family.
 _____	I acknowledge that I was provided a copy of the Office Financial Policy and that I have read and or had the opportunity to read and understand the Policy. I understand that I am ultimately financially responsible for all fees incurred in the dental/orthodontic office.	
I certify the above information to be correct and understand it is my responsibility to inform the practice of any changes. I authorize the completion of all mutually agreed upon necessary dental and/or orthodontic services.		
 (SEAL)	_____	_____
Parent/Guardian Signature	Print Name	Date

Please complete BOTH SIDES of the registration form so we may give your child the very best care. Thank you.

MEDICAL HISTORY

Patient Name: _____ Nickname (if any): _____ Date of Birth: _____

Child's Physician: _____ Address: _____ Phone: _____

Date of last physical examination: _____ Results: _____

Child's weight (pounds): _____ Child's height: _____ Immunization's up to date? Yes No

Is a physician treating your child now for a specific illness? Yes No If yes, for what reason? _____

Check and Discuss with the Doctor any medical condition that the child has or has had:

Allergies : Latex Drugs* Foods* / Coloring Metals / Plastics Seasonal

* Please list which drugs or foods: _____

- | | | |
|--|---|--|
| <input type="radio"/> Accidents or severe infections | <input type="radio"/> Cerebral Palsy | <input type="radio"/> Liver Disease/Hepatitis |
| <input type="radio"/> Skin Problems | <input type="radio"/> Autism/Aspergers Syndrome/PDD | <input type="radio"/> Diabetes |
| <input type="radio"/> Anemia or Blood Disorders | <input type="radio"/> Immune Deficiencies/Problems | <input type="radio"/> AIDS or HIV + |
| <input type="radio"/> Headaches | <input type="radio"/> Asthma or Lung Problems | <input type="radio"/> Bleeding problems |
| <input type="radio"/> Convulsions, seizures, or epilepsy | <input type="radio"/> Vision Problems | <input type="radio"/> Kidney or Bladder Problems |
| <input type="radio"/> Taking Bisphosphonates | <input type="radio"/> Speech or Hearing Impairments | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Hospital Stays or Operations | <input type="radio"/> Malignancies (Cancer) | <input type="radio"/> Hyperactivity/ADHD/ADD (please circle) |
| <input type="radio"/> Blood Transfusions | <input type="radio"/> Heart Conditions | <input type="radio"/> Prematurity |
| <input type="radio"/> Psychiatric care | <input type="radio"/> Skeletal/Joint conditions/Problems | <input type="radio"/> Special Diet ** Please describe below |
| <input type="radio"/> Genetic Conditions **Please describe below | <input type="radio"/> Developmental Disabilities ** Please describe below | |

** Description of medical condition _____

Is your child taking any medications (please include any vitamins and/or supplements)? Yes No (if yes please list below)

<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason</u>
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Please describe any current medical treatment including drugs, pending or recent surgery, recent injuries or any other information the dentist should be aware of that has not been covered above. _____

Complete for Dental Patients Only

Why did you bring the child to the dentist today? _____

Is there pain or discomfort? Yes No

Have there been any injuries to the face, mouth, teeth or chin?
 Yes No

Is this your child's first visit to the dentist? Yes No

Previous Dentist: _____

Date of last visit: _____

Has your child experienced problems with previous dental care?
 Yes No

If yes, please explain: _____

Do you have any special concerns to discuss with the doctor in private?
 Yes No

Home the child currently resides has: Well Water City Water

Complete for Orthodontic Patients Only

Who is your Childs General Dentist? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have there been any injuries to the face, mouth, teeth or chin?
 Yes No

Has your child ever been evaluated or had orthodontic treatment before?
 Yes No

Have adenoids or tonsils been removed? Yes No

Has your child been informed of any missing or extra permanent teeth?
 Yes No

Has your child ever had any pain/tenderness in his/her jaw joint/ (TMJ/TMD)? Yes No

Has your child ever experienced any of the following?

Clenching / Grinding Teeth Yes No

Speech Problems Yes No

Thumb/Finger Sucking Yes No

Mouth Breather Yes No

Doctor Notes: _____

Doctor Review and Signature: _____ Date: _____