



SOUTH GEORGIA
PEDIATRIC DENTISTRY

3227 North Oak Street Extension, Suite A
Valdosta, Georgia 31605
Phone (229) 247-3200 • (229) 241-1900

**PATIENT
REGISTRATION
FORM**

TELL US ABOUT YOUR CHILD

Child's name _____ Nickname _____ Male Female
 Child's birthdate _____ Child's age _____ School _____ Grade _____
 Child's home address _____ City _____ State _____ Zip Code _____
 Child's home number _____ Social Security # _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name _____ Relation _____ Do you have legal custody of the child? Yes No
 In case of emergency, contact other than self (name & telephone) _____
 Whom may we thank for this referral? _____

PERSON RESPONSIBLE FOR ACCOUNT

Mother's Information

Name _____ Date of Birth _____
 Address _____ For how long? _____
 Employed by _____ For how long? _____
 Occupation _____
 SS# _____
 Driver's license # _____
 Business phone _____
 Home phone _____
 Cell phone _____ E-mail _____

Father's Information

Name _____ Date of Birth _____
 Address _____ For how long? _____
 Employed by _____ For how long? _____
 Occupation _____
 SS# _____
 Driver's license # _____
 Business phone _____
 Home phone _____
 Cell phone _____ E-mail _____

DENTAL INSURANCE COMPANY

(Only primary insurance will be filed)

Insurance Co. name _____
 Insurance Co. address _____
 Insurance Co. phone _____ Group # (plan, local, or policy #) _____
 Insured's name _____ Relationship to child _____
 Insured's birthdate _____ ID # _____ Insured's employer _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Sellers & Dr. Fields, otherwise payable to SGPD. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

SIGNATURE OF PARENT/ GUARDIAN

DATE

Date _____

MEDICAL HISTORY

- 1. Is your child under care of a physician? _____ Yes No
If yes, since when and why? _____
- 2. Name of physician _____
- 3. Is your child receiving any medication? _____ Yes No
List current medications _____
- 4. Is your child allergic to any drugs, such as penicillin? _____ Yes No
- 5. Does your child have other allergies? _____ Yes No
- 6. Has your child had any serious illness? _____ Yes No
- 7. Has your child ever had surgery or been hospitalized? _____ Yes No
- 8. Has your child had a history of any of the following? Please check a response for each question:
- Heart trouble, murmur, or surgery _____ Yes No
- Rheumatic fever or scarlet fever _____ Yes No
- Asthma, TB, or lung problems _____ Yes No
- HIV infection or AIDS _____ Yes No
- Hemophilia or bleeding problems _____ Yes No
- Sickle cell anemia/blood disorder _____ Yes No
- Hepatitis or liver problems _____ Yes No
- Kidney infection _____ Yes No
- Diabetes _____ Yes No
- Cancer, tumor, leukemia _____ Yes No
- Thyroid or other glandular problems _____ Yes No
- Latex or rubber allergy _____ Yes No
- Epilepsy, seizures, fainting _____ Yes No
- Cerebral palsy or developmental delay _____ Yes No
- Vision problems _____ Yes No
- Speech or hearing problems _____ Yes No
- Emotional or psychological problems _____ Yes No
- Congenital birth defects _____ Yes No
- Cleft lip or palate _____ Yes No
- Malignant hyperthermia _____ Yes No
- Other medical condition _____ Yes No
- Is parent or patient pregnant? _____ Yes No

COMMENTS <i>(for office use only)</i>	Med. Alert

PURPOSE OF TODAY'S VISIT _____

MEDICAL HISTORY

- 1. When and where was your child's last dental visit? _____
- 2. What was the purpose of that visit? _____
- 3. Were any x-rays taken at your child's last dental visit? _____ Yes No
- 4. Did your child have difficulty cooperating? _____ Yes No
- 5. Was/is your child bottle fed? _____ Yes No
- 6. Was/is your child breast fed? _____ Yes No
- 7. If your child has been weaned, please indicate at what age _____
- 8. When does your child brush his/her teeth?
 Upon arising After eating any food
 Right after meals Before going to bed
- 9. Do you assist/supervise your child/s brushing? _____ Yes No
- 10. Does your child take fluoride supplements? _____ Yes No
- 11. Have any cavities been noted in the past? _____ Yes No
- 12. Were any teeth (baby or permanent) removed by extraction? _____ Yes No
- 13. Have there been any injuries to teeth, such as falls, blows, chips, etc.? _____ Yes No
- 14. Has anyone in the family, including parents, had orthodontics? _____ Yes No
- 15. Has your child had a toothache recently? _____ Yes No
If yes, explain: _____
- 16. Do you expect your child to be cooperative? _____ Yes No
- 17. Does your child have other siblings seen by us? _____ Yes No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be rendered. I give my consent to Dr. Sellers & Dr. Fields and their staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

SIGNATURE OF PARENT/GUARDIAN

DATE