PATIENT REGISTRATION FORM

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

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. Thomas, otherwise payable to me. 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
(for office use only)

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 assisst/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. Thomas and her 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