# IRVING FAMILY DENTAL

## New Patient Registration Form

**PATIENT LAST NAME:**________________________ **FIRST:**______________________ **INITIAL:** ____________

How do you wish to address? ______________________________ DOB ______________

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School______________

Address ____________________________________________

City________________________ State______________ Zip ______________

Telephone (Home) ______________ (Work) ______________ (Mobile) ______________

Email ____________________________________________

Employer ______________________ Occupation ______________

Soc. Sec. No. ______________ Dental Insurance Co. ______________ Group______________

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. ______________

How did you hear about our practice? Whom may we thank for your referral? ______________

## HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name________________________ First______________________ Initial ______________

Address____________________________________________ DOB ______________

City________________________ State_____ Zip ______________

Telephone (Home)______________ (Work)______________ (Mobile) ______________

Email____________________________________________

Employer________________________ Occupation ___

Soc. Sec. No.______________ Dental Insurance Co.______________ Group ______________

## WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name________________________ First______________________ Initial ______________

Address____________________________________________ DOB ______________

City________________________ State______________ Zip______________

Telephone (Home)______________ (Work)______________ (Mobile) ______________

Email____________________________________________

Employer________________________ Occupation ______________

Soc. Sec. No. ______________ Dental Insurance Co. ______________ Group ______________

## NEAREST RELATIVE

Last Name ________________________ First______________________ Initial______________

Address ____________________________________________

City______________ State______ Zip__________ E-Mail ______________

Telephone (Home)______________ (Work)______________ (Mobile) ______________

## AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature________________________________________ Date ______________

# IRVING FAMILY DENTAL

## Medical and Dental History for Children 12 and Under

Patient Name______________________________D.O.B.________________

Parent/Guardian's Name____________________Relationship to Child____________

Emergency Contact (Name/Phone Number) ______________________________

## Medical History

1. Does your child have any current health problems?........................ ☐Yes ☐No
   If yes, please explain ______________________________
2. Is your child under care of a physician? ........................ ☐Yes ☐No
   Name of physician______________________________
3. Is your child receiving any medications? ........................ ☐Yes ☐No
   If so, what and when?______________________________
4. Has your child had any serious illness? ........................ ☐Yes ☐No
   If so, what and when?______________________________
5. Has your child ever had surgery or is surgery contemplated? ........................ ☐Yes ☐No
   Explain ______________________________
6. Does your child have a heart murmur or any other heart condition? ........................ ☐Yes ☐No
7. Does your child experience severe or prolonged bleeding? ........................ ☐Yes ☐No
   Explain______________________________
8. Does your child have AIDS or has he/she tested HIV positive? ........................ ☐Yes ☐No
9. Has your child tested positive for hepatitis? ........................ ☐Yes ☐No
10. Has your child had a history of nervous disorders?........................ ☐Yes ☐No
11. Does your child have frequent headaches? ........................ ☐Yes ☐No
    Explain______________________________
12. Is your child allergic to: (circle) None Codeine Penicillin Local Anesthetic Latex Dyes Other
    ______________________________
13. Has your child had history of:

| | | | |
|---|---|---|---|
| Diabetes........ | ☐Yes ☐No | Cerebral palsy ........ | ☐Yes ☐No |
| Asthma........ | ☐Yes ☐No | Cancer........ | ☐Yes ☐No |
| Hay fever........ | ☐Yes ☐No | Leukemia........ | ☐Yes ☐No |
| Kidney infection........ | ☐Yes ☐No | Oral Herpetic Lesion........ | ☐Yes ☐No |
| Liver problems ........ | ☐Yes ☐No | Eating Disorders ........ | ☐Yes ☐No |
| Hepatitis/ Jaundice ........ | ☐Yes ☐No | Speech impairments........ | ☐Yes ☐No |
| Thyroid Problems........ | ☐Yes ☐No | Hearing Impaired........ | ☐Yes ☐No |
| Rheumatic fever ........ | ☐Yes ☐No | Take pre-medication for anything........ | ☐Yes ☐No |
| Epilepsy/ Seizures/ Fainting........ | ☐Yes ☐No | If yes, what for ______________ | |

# IRVING FAMILY DENTAL

## Dental History

| Question | Y | N |
|---|---|---|
| This is my child's first visit to the dentist? | ☐ | ☐ |
| When does your child brush his/ her teeth? | | |
| (Circle) Upon arising After any food Right after meals Before bedtime | | |
| Do you currently monitor your child's sugar intake in food, snacks and drinks? | ☐ | ☐ |
| Does your child receive Fluoride in their drinking water? | ☐ | ☐ |
| Does your child receive supplemental Fluoride at home? | ☐ | ☐ |
| Have any cavities been noted in the past? | ☐ | ☐ |
| Does your child suck his/her thumb or fingers? | ☐ | ☐ |
| Were any teeth (baby or permanent) removed by extraction? | ☐ | ☐ |
| Has a space maintainer been recommended? | ☐ | ☐ |
| Has a space maintainer been placed? | ☐ | ☐ |
| Has your child had any problem with dental treatment in the past? | ☐ | ☐ |
| Has anyone in the family, including parents, had orthodontics? | ☐ | ☐ |
| Has your child ever received a local anesthetic? | | |
| Has your child ever had occlusal sealants? If so, when? | ☐ | ☐ |
| Does your child think there is anything wrong with his/her teeth? | ☐ | ☐ |
| Have there been any injuries to teeth, such as falls, blows, chips, etc.? | ☐ | ☐ |
| Does your child grind, clench or brux their teeth? | ☐ | ☐ |
| Explain_______________________________________________ | | |
| Does your child snore? | ☐ | ☐ |
| Is there anything else that would be of valuable for your dentist to know to best care for you? | ☐ | ☐ |
| Explain_______________________________________________ | | |

- I authorize the dentist to perform diagnostic procedures and treatment as deemed necessary for proper dental care.
- I authorize the release of any information concerning my child's healthcare, advice and treatment provided for the purpose of improved treatment outcomes and/or evaluating and administering claims for insurance benefits.
- I attest to the accuracy of the information on this page and understand that it is my responsibility to inform the Doctor and the office staff of any changes in my child's medical status at the very next appointment, before any further treatment is rendered.

Patient's / Guardian's Signature_______________________________________________Date_______________

Dentist's Signature_______________________________________________Date_______________

Medical Clearance needed: Yes No Dentist's Signature:_________________Date_______________
Medical Clearance Received: Yes No Dentist's Signature:_________________Date_______________
Medical Clearance Reviewed: Yes No Dentist's Signature:_________________Date_______________