Aldrich Pediatric Dentistry

NEW PATIENT REGISTRATION

WELCOME! THANK YOU FOR ALLOWING US THE RESPONSIBILITY OF CARING FOR YOUR CHILD!

WE LOOK FORWARD TO SERVING YOUR CHILD'S DENTAL NEEDS!

Child's Name: _____ Date of Birth: ___/___/_____ Gender: ☐ M ☐ F

Address:_____
City State Zip Code

Primary Phone Number for Appointment Confirmation : (_____) _____-_____

Who Brought the Child Today? _____

Guardian Information:

Name:_____
Relationship to child: _____
Gender: ☐ M ☐ F DOB: ___/___/_____
Home# : (___) ___-_____ Cell# : (___)-___-_____
Social Security Number (SSN) : ____-____-_____
Email Address: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Domestic Partnership
Address (if different from above):
_____
_____

Name:_____
Relationship to child: _____
Gender: ☐ M ☐ F DOB: ___/___/_____
Home# : (___) ___-_____ Cell# : (___)-___-_____
Social Security Number (SSN) : ____-____-_____
Email Address: _____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Domestic Partnership
Address (if different from above):
_____
_____

Primary Insurance Coverage

Name of Insured:_____
DOB: ___/___/_____ SSN:_____-_____-_____
Phone: (_____) _____-_____
Employer:_____
Address:_____
_____
Phone: (_____) _____-_____
Group/Policy # : _____
ID # :_____

Secondary Insurance Coverage (if applicable)

Name of Insured:_____
DOB: ___/___/_____ SSN:_____-_____-_____
Phone: (_____) _____-_____
Employer:_____
Address:_____
_____
Phone: (_____) _____-_____
Group/Policy # : _____
ID # :_____

Child's Name: _____

Date of Child's last Physician Visit/Reason:_____/_____

Current Medications: _____

Name/Phone of Primary Care physician:_____/_____

Name/Phone of Specialist Physicians(if any):_____

_____

Medical History

Please mark "YES" if your child has a history of the following. For each "YES", please provide details in the area below.

	Y	N
Congenital Heart Disease	☐	☐
Asthma	☐	☐
ADD/ADHD	☐	☐
Autism Spectrum	☐	☐
Seizures/Epilepsy	☐	☐
Anemia/Bleeding Disorder	☐	☐
Hemophilia	☐	☐
Abnormal Bleeding	☐	☐
Immune Disorder	☐	☐
HIV/AIDS	☐	☐
Cancer/Tumor	☐	☐
Leukemia	☐	☐
Stomach/GI Complications	☐	☐

	Y	N
Diabetes	☐	☐
Metabolic Disorder	☐	☐
Operations	☐	☐
Overnight Hospitalizations	☐	☐
Kidney Disease	☐	☐
Hearing Problems/Deaf	☐	☐
Cerebral Palsy	☐	☐
Cystic Fibrosis	☐	☐
Congenital Birth Defects	☐	☐
Liver Disease/Hepatitis	☐	☐
Premature/Low Birth Weight	☐	☐
Social/Cognitive/Mental Delay	☐	☐
Other	☐	☐

Allergies:

	Y	N	
Food	☐	☐	:_____
Medication	☐	☐	:_____
Latex	☐	☐	
Seasonal	☐	☐	

Elaborate on "YES" answers here: _____

_____

_____

_____

_____

Child's Name: _____

If there is any other pertinent information relating to your child's medical history and/or his/her family of which the dentist should be informed, please list:

_____
_____
_____
_____

Dental History

What is the primary purpose of today's visit? _____

Is today your child's first dental visit? ☐ Yes ☐ No

If no, who was child's previous dentist/last visit/why? _____

_____/_____/_____

Do you believe your child will react well to today's treatment? ☐ Yes ☐ No

What do you think we can do to make your child's visit a positive experience? _____

_____

At the present time, does your child (check all that apply):

☐ Use pacifier ☐ Suck thumb/fingers ☐ Grind teeth ☐ Bite nails ☐ Chew on any objects
☐ Chew on tongue/cheek/lips ☐ Tongue thrust ☐ Mouth Breathe ☐ Breastfeed ☐ Bottle feed
☐ Use sippy cup ☐ Take anything to drink in bed (besides water)

Dental Routine (check all that apply):

☐ Fluoridated toothpaste ☐ Fluoridated mouthwash ☐ Drink fluoridated water
☐ Brush alone/times daily ___ ☐ Brushing by parent/times daily ___ ☐ Dental floss/times per week ____

Whom may we thank for referring you to our office? _____

I confirm that all information above is current and correct to the best of my knowledge. I, further acknowledge that if any changes occur, it is my responsibility to report them to this office. I authorize the dental staff to perform any necessary dental treatment on my child. I am aware the Aldrich Pediatric Dentistry may use/disclose any necessary/pertinent health information and dental records to other dental/healthcare specialists to coordinate and manage dental care and related services. I authorize the release of all information necessary to secure benefits such as confirmation of coverage, bill and collection activities and obtaining reimbursement for service. I understand that I am responsible for the full balance on my account regardless of dental benefits. I further assign all dental benefits made payable to me to Aldrich Pediatric Dentistry. In the event of default, I agree to pay all reasonable costs and fees associated with the collection of my account balance, including but not limited to court filing fees, attorney fees, and third party collection fees. I affirm that my signature below is in agreement to all terms above and answered questions on this form.

Guardian's signature: _____ Date: _____