Patient Registration

Date (MM/DD/YYYY): _____

Social Security Number: _____

Child's Full Legal Name: _____ Nickname: _____

Address: _____ City: _____ State: __ Zip: _____

Phone with text reminders: _____ Email: _____

Who has legal custody of child? _____

Who is accompanying child today? _____ Relationship to child: _____

Child's Age: _____ Birthdate: _____ Weight: _____ ☐ Male ☐ Female

Name & age of siblings: _____

Previous Dentist: _____ Phone: _____ Last Visit: _____

Child's Physician: _____ Phone: _____

Alternate Contact Person (not living with patient): _____ Phone: _____

Alternate Contact's Relationship (to patient): _____

Parent Name: _____ Parent Birthdate: _____

Home Address (if different): _____

Phone (if different): _____ Cell: _____ Email: _____

Parent Name: _____ Parent Birthdate: _____

Home Address (if different): _____

Phone (if different): _____ Cell: _____ Email: _____

Insurance Information

Primary Dental Insurance Co: _____ Phone: _____

Address: _____

Insured's Name: _____ Insured's ID#: _____

Employer: _____ Group Number: _____

Secondary Dental Insurance Co: _____ Phone: _____

Address: _____

Insured's Name: _____ Insured's ID#: _____

Employer: _____ Group Number: _____

Child's Name: _____

Health History

If your child has, and has had any of the following, please check Y (Yes) or N (No):

☐ Y ☐ N Asthma	☐ Y ☐ N Abnormal Bleeding	☐ Y ☐ N Allergies to any drug
☐ Y ☐ N Hepatitis	☐ Y ☐ N HIV/ AIDS	☐ Y ☐ N Hemophilia
☐ Y ☐ N Heart Disease	☐ Y ☐ N Cancer	☐ Y ☐ N Diabetes
☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Latex Allergy	☐ Y ☐ N Tuberculosis
☐ Y ☐ N Seizures/ Convulsions	☐ Y ☐ N Rheumatic Fever	☐ Y ☐ N Developmental Disability
☐ Y ☐ N Speech/ Hearing/ Eye Issues	☐ Y ☐ N Kidney/ Liver Issues	☐ Y ☐ N Intellectual Disability

Please explain any above problems that were checked yes or any problems not listed:

Please discuss any serious medical problems or hospitalizations that your child has had:

Please list all allergies, sensitivities, and/ or reactions:

Please list all medications your child currently takes:

Please list any history of behavioral or emotional problems your child has experienced:

Home Water Supply: ☐ City ☐ Well ☐ Bottled

Does your child have the following habits? ☐ Grinds Teeth ☐ Pacifier ☐ Finger/ Thumb Habit

Has your child had difficulty with previous medical or dental visits? Explain:

Do you have difficulty at home brushing your child's teeth? Explain:

How did you hear about our office? _____

I hereby assign to Richard H Gentzler III DDS Pediatric Dentistry PLLC all money which I am entitled for dental expenses relative to the service rendered by him, but not to exceed my indebtedness to said dentist. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said dentist for charges not covered by my insurance agreement). Also, I authorize Richard H Gentzler III DDS Pediatric Dentistry PLLC to examine my child and render treatment deemed necessary for my child's health including a dental prophylaxis, fluoride application, dental photos, or radiographs for my child's dental record as needed.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Richard H Gentzler III DDS Pediatric Dentistry PLLC of any changes in my child's medical status. I authorize the said dentist and healthcare staff to perform the necessary services my child may need.

Parent/ Guardian's Signature _____ Date _____