Post Oak
Pediatric Dentistry

NEW PATIENT REGISTRATION

Child's name: ____
Last First Middle (Preferred)

Date of Birth: ___________________________ Home Phone: ________-____-_________ Gender: [ ] M, [ ] F

Address ____ City______________ State ____ ZIP __________

Grade _____________ Patient's School ____

Other children and their ages: ____

How did you hear about us? ____

Father's name	_________________________	Mother's name	_________________________
DOB	_________________________	DOB	_________________________
SSN	_______ - ______ - _________	SSN	_______ - ______ - _________
Cell phone	_________________________	Cell phone	_________________________
Email	_________________________	Email	_________________________
Work phone	_________________________	Work phone	_________________________
Employer	_________________________	Employer	_________________________

Preferred contact method

Father [ ] Home phone, [ ] Cell phone, [ ] Work phone, [ ] Email

Mom [ ] Home phone, [ ] Cell phone, [ ] Work phone, [ ] Email

Do both parents and child(ren) live together? [ ] Y, [ ] N

Other than parents, is there anyone authorized to bring child(ren) and sign for child's care and treatment?
[ ] Y, [ ] N. (If Y, please complete the below.)

Name ______________________________________ Relation to child_____________________________

Cell Phone _____________________

Is child insured? [ ] Yes, [ ] No

Insurance policy 1

Subscriber Full Name _______________________________________ DOB: ___________________________

Subscriber ID: _________________ Insurance co. & phone #:________________________#:________________

Employer: _____________________________________ Group #: _____________________________________

Relation to child: _______________________________ **Please present insurance card to the front office**

Insurance policy 2

Subscriber Full Name _______________________________________ DOB: ___________________________

Subscriber ID: _________________ Insurance co. & phone #:________________________#:________________

Employer: _____________________________________ Group #: _____________________________________

Relation to child: _______________________________ **Please present insurance card to the front office**

Comment

Medical History

Patient: Last Name:____________________ First Name: ____________________ Birthdate:______________
Name of Medical Doctor:__________________________City/State: ______________________________
Emergency Contact:______________________ Phone:__________________ Relationship ____________

List all Medications your child is taken and the reason why:

- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____

Is your child allergic to any of the following?

Y	N	
☐	☐	Anesthetic
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen
☐	☐	Peanuts
☐	☐	Tree Nut
☐	☐	Iodine
☐	☐	Latex
☐	☐	Penicillin/ Amoxicillin
☐	☐	Sulfa
☐	☐	Does your child have any other allergies, please list: ________________________

Does your child have any of the following medical conditions?

Y	N	
☐	☐	Asthma
☐	☐	Bleeding Problems
☐	☐	Autism
☐	☐	Heart Murmur, Ailment for Heart trouble
☐	☐	ADHD
☐	☐	Anemia
☐	☐	Seizures
☐	☐	Sensory Disorder
☐	☐	Kidney Disease
☐	☐	Speech problem
☐	☐	Mouth breather
☐	☐	Psychiatric Treatment
☐	☐	Sinus Trouble
☐	☐	Ulcers
☐	☐	Rheumatic Fever
☐	☐	Others, please list: ________________________

Does your child have any of the following habits? (CIRCLE) Thumb sucking, Finger habit, Teeth Grinding, Pacifier, Nail biting, Tongue Thrusting? Please list any other habits that your child has:
____

Has patient ever had an unusual reaction to dental anesthetic and/ or dental procedure? YES NO
Please explain: ____
Reason for today's visit?______________________________ Is your child in pain?________________
What is the name and location of your child's last dentist? _________________ Date of last visit? __________
Reason: ____________ Last date your child had X-rays taken? _________ Type of x-rays taken? ___________
Do you have any special concerns you would like to discuss at today's visit? _______________________
Who brushes and flosses your child's teeth? __________________ How often? ____________________
Is Toothpaste Used? YES NO Does it contain Fluoride? YES NO

Parent/Guardian Signature: ______________________Relationship: ______________ Date: ______________

Medical History Reviewed By: ___________________________ Date Reviewed: _________________________