

PATIENT'S REGISTRATION AND HISTORY



Bridget McAnthony, DDS, PA

Dentistry Dedicated to CHILDREN



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Keller TX 76248

Ph: (817) 788-9500 Fax: (817) 520-1556

Date: _____

Child's Name: _____ Nickname: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Gender: _____ Home Phone: _____ Best Time to Call: _____

Address: _____ City/State: _____ Zip: _____

Who referred your child to our office? _____

GENERAL INFORMATION

Father/Guardian: _____

Mother/Guardian: _____

SS#: _____

SS#: _____

Texas Driver's License#: _____

Texas Driver's License#: _____

Place of Employment: _____

Place of Employment: _____

Work Phone: _____

Work Phone: _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Marital Status of Parents: _____

If not biological parent what is your relationship to this child? _____

DENTAL INSURANCE

Insured's Name: _____ Relationship to Patient: _____

Insured's Birth Date: _____ SS#: _____ Insurance ID #: _____

Employer: _____ Insurance Group #: _____ Policy #: _____

Insurance Company: _____ Phone#: _____

Insurance Address: _____ City/State: _____ Zip: _____

EMERGENCY

Besides the parents/guardian listed above, whom should we contact in the event of an emergency?

Name: _____ Relationship: _____ Phone: _____

PARENT QUESTIONS

1. How do you feel about this appointment?
 Good Moderately Nervous Nervous
2. How do you expect your child to react to dental treatment?
 Good Moderately Nervous Nervous
3. Do you desire comprehensive dental care for your child?
 Yes No

CHILD'S DENTAL HISTORY

How often does your child brush? : _____ How often does your child floss? : _____

Date of last dental visit: _____ For what dental procedure? : _____

Previous Dentist : _____ City/State : _____ Phone # : _____

Has your child had any unfavorable dental experiences? _____ If yes please explain: _____

Has your child ever had a local anesthetic? _____ If yes, were there any difficulties? _____

Has your child had any injuries to the mouth or teeth? _____ If yes please explain: _____

Is your child's water fluoridated? : _____ Does your child take fluoride in any form? : _____

Does your child:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Suck thumb/finger | <input type="checkbox"/> Suck/Bite lips | <input type="checkbox"/> Bite/Chew nails | <input type="checkbox"/> Grind Teeth |
| <input type="checkbox"/> Clench jaws | <input type="checkbox"/> Pacifier | <input type="checkbox"/> Take bottle at night | <input type="checkbox"/> Breastfeeding |

CHILD'S MEDICAL HISTORY

Child's Physician: _____ City/State: _____ Phone: _____

Date of last physical examination? : _____ Results: _____

Is child under care of a physician now? _____ If yes please explain: _____

Has your child ever been hospitalized? _____ If yes please explain: _____

Has your child ever had any surgery? _____ If yes please explain: _____

Does your child have any allergies (penicillin, latex, etc.)? _____ If yes please list: _____

Is your child currently taking any medications now? _____ If yes please list name and frequency: _____

Is your child current on all vaccinations? _____

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child: _____

CHILD'S HEALTH HISTORY

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____ If yes please explain: _____

Has your child ever taken Fen-Phen/Redux? _____ If yes please explain: _____

Has your child ever had a blood transfusion? _____ If yes, give approximate date: _____

Is your child currently taking any herbal supplements? _____ If yes, list name and frequency: _____

My child has had, or currently has the following:

Asthma: Yes No

Anemia: Yes No

Blood Disease: Yes No

Bleeding Disorder: Yes No

Cancer: Yes No

Cerebral Palsy: Yes No

Congenital Heart Defect: Yes No

Organ Transplant: Yes No

Diabetes: Yes No

Epilepsy/Seizures: Yes No

Fainting: Yes No

Hearing Disorder: Yes No

ADD/ODD: Yes No

Heart Murmur Yes No

Hepatitis: Yes No

Kidney Disorder: Yes No

Liver Disease: Yes No

Lung Disease: Yes No

Mental Disorders: Yes No

Rheumatic Fever: Yes No

Sinus Problems/ seasonal allergies: Yes No

Thyroid Disorder: Yes No

Vision Disorder: Yes No

AIDS/HIV+: Yes No

Tuberculosis: Yes No

Other not listed: _____

If age appropriate and female, date of last cycle: _____ Are you taking birth control pills? _____

Possible Pregnancy? _____

If you answered yes to any of the above, please explain: _____

Has your child experienced bloody sputum, night sweats, weight loss or fever? _____ If you answered yes to any of these, please list and explain: _____

CONSENT FOR TREATMENT OF A MINOR

The undersigned hereby authorizes Dr. McAnthony to perform the examination including x-rays, and after explanation, all forms of treatment, medication and therapy indicated for the dental care of the above named child. This consent shall remain in force and effect until cancelled by either party.

Signature of Parent/Guardian

Date

AUTHORIZATIONS AND RELEASE

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, and it is my responsibility to inform the dental office of any changes in my child's medical status.

_____ Initial

I authorize Dr. McAnthony and her staff to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

_____ Initial

I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents whether or not charges are paid by insurance.

_____ Initial

I have read and have had any questions I may have had concerning any of the above statements answered to my complete understanding.

_____ Initial

I authorize the use of this signature on all my insurance submissions.

Signature of Parent/Guardian

Date