Patient Registration Form

Patient's name: _____ Date of Birth: ____/____/____ Male / Female

Mother's name: _____Date of Birth: ____/____/____ SS#: _____

Mother's Employer: _____ Email: _____

Mother's Cell Phone: _____ Other Phone: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Father's Name: _____Date of Birth: _____ SS#: _____

Father's Employer: _____ Cell Phone: _____

INSURANCE

Primary Insurance Company: _____

Subscriber name: _____ Employer: _____

Subscriber # or SS#: _____ Group #: _____

Secondary Insurance Company: _____

Subscriber # or SS#: _____ Group #: _____

Insurance Phone Number: _____

Insurance is a contract between you and your insurance company. We bill your insurance company as a courtesy to you, but note that payment is due at time of service. Although we estimate your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You must agree to pay any portion of the charges not covered by the insurance.

I hereby authorize payment by my dental insurance company be directly paid to Harbor Kids Dental. I also authorize the release of any dental information necessary to process dental claims. At the discretion of the office, we may use the services of one or more credit reporting services. I acknowledge receipt of the notice of privacy practices.

Parent/Guardian Signature: _____ Date: _____

Dental History

Child's Name:_____ Date of Birth:____/____/____ ☐ Male ☐ Female

How did you hear about us? _____

Does your child have an unusual history of the following:

☐ Nursing/Bottle Habits ☐ Pacifier ☐ Thumb/Finger Sucking ☐ Dental Grinding

MEDICAL HISTORY

Name of Child's Physician:_____Phone: _____

Is Child taking any medications? ☐ Yes ☐ No If yes, what?_____

Is Child allergic to any of the following medications or substances? ☐ Yes ☐ No

☐ Aspirin ☐ Penicillin ☐ Latex ☐ Foods ☐ Metal/Acrylics ☐ Other:_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

AIDS/HIV ☐ YES ☐ NO	Cerebral Palsy ☐ YES ☐ NO	Growth Problems ☐ YES ☐ NO	Orthopedic Problems ☐ YES ☐ NO
Anemia ☐ YES ☐ NO	Chemotherapy ☐ YES ☐ NO	Heart Murmur/ Heart Problems ☐ YES ☐ NO	Tobacco Use ☐ YES ☐ NO
Asthma/Breathing Problems ☐ YES ☐ NO	Child Abuse ☐ YES ☐ NO	Hepatitis/ Liver Disease ☐ YES ☐ NO	Pregnancy ☐ YES ☐ NO
Autism ☐ YES ☐ NO	Chronic Adenoid/ Tonsil Problems ☐ YES ☐ NO	High Blood Pressure ☐ YES ☐ NO	Ulcers ☐ YES ☐ NO
Arthritis ☐ YES ☐ NO	Cleft Lip/Palate ☐ YES ☐ NO	Bladder Conditions ☐ YES ☐ NO	Diabetes ☐ YES ☐ NO
ADHD ☐ YES ☐ NO	Developmentally Delayed ☐ YES ☐ NO	Kidney Disease ☐ YES ☐ NO	Disabilities/ Special Need ☐ YES ☐ NO
Birth Defects ☐ YES ☐ NO	Drug/Alcohol Use ☐ YES ☐ NO	Leukemia ☐ YES ☐ NO	Speech/Hearing Problems ☐ YES ☐ NO
Brain Injury ☐ YES ☐ NO	Emotional Disturbance ☐ YES ☐ NO	Sickle Cell Anemia ☐ YES ☐ NO	Convulsions/ Seizures ☐ YES ☐ NO
Bruise Easily ☐ YES ☐ NO	Excessive Gagging ☐ YES ☐ NO	Tuberculosis ☐ YES ☐ NO	Tumors/Growth ☐ YES ☐ NO
Bleeding/ Clotting Problems ☐ YES ☐ NO	Fainting/Dizziness ☐ YES ☐ NO	Prosthetic Joints/ Pins ☐ YES ☐ NO	Psychiatric Care ☐ YES ☐ NO
Cancer ☐ YES ☐ NO	Fever Blisters ☐ YES ☐ NO		

If answered **"YES"** to any of the above, please explain: _____

_____

Parent/
Guardian: _____ Date: _____ Doctor: _____ Date: _____

Parent/
Guardian: _____ Date: _____ (1) Doctor: _____ Date: _____

Parent/
Guardian: _____ Date: _____ (2) Doctor: _____ Date: _____