# SPRINGFIELD LORTON DENTAL GROUP

## CHILD REGISTRATION FORM

| LAST NAME | FIRST NAME | MI | SSN |
|---|---|---|---|

| DOB | GENDER: M / F | NAME OF PARENTS: |
|---|---|---|

ADDRESS

| CITY | STATE | ZIP | HOME PHONE |
|---|---|---|---|

| MOM WORK # | DAD WORK # | CELL PHONE # |
|---|---|---|

| MOM'S EMPLOYER | POSITION |
|---|---|
| DAD'S EMPLOYER | POSITION |

| PHYSICIAN | PHONE# | CITY/STATE |
|---|---|---|

| EMERGENCY CONTACT | EMERGENCY PHONE # |
|---|---|
| REFERRED TO OFFICE BY: | PARENT'S E-MAIL ADDRESS: |

## MEDICAL HISTORY:

| Y | N | CONDITIONS | Y | N | CONDITIONS | Y | N | CONDITIONS |
|---|---|---|---|---|---|---|---|---|
| | | ABNORMAL BLEEDING | | | GLAUCOMA | | | STROKE |
| | | ALCOHOL ABUSE | | | HIV+ AIDS | | | THYROID PROBLEMS |
| | | ALLERGIES | | | HAY FEVER | | | TUBERCULOSIS |
| | | ANEMIA | | | HEART ATTACK | | | ULCERS |
| | | ANGINA PECTORIS | | | HEART MURMUR | | | YELLOW JAUNDICE |
| | | ARTHRITIS | | | HEART SURGERY | **Y** | **N** | **ALLERGIES** |
| | | ARTIFICIAL BONES | | | HEMOPHILIA | | | ASPIRIN |
| | | ARTIFICIAL HEART VALVE | | | HEPATITIS A | | | CODEINE |
| | | ASTHMA | | | HEPATITIS B | | | DENTAL ANESTHETICS |
| | | BLOOD TRANSFUSION | | | HEPATITIS C | | | ERYTHROMYCIN |
| | | CANCER-CHEMOTHERAPY | | | HIGH BLOOD PRESSURE | | | JEWELRY |
| | | COLITIS | | | KIDNEY PROBLEMS | | | LATEX |
| | | CONGENITAL HEART DEFECT | | | LIVER DISEASE | | | METALS |
| | | COSMETIC SURGERY | | | LOW BLOOD PRESSURE | | | PENICILLIN |
| | | DIABETES | | | MITRAL VALVE PROLAPSE | | | TETRACYCLINE |
| | | DIFFICULTY BREATHING | | | PREMED | OTHER ALLERGIES: | | |
| | | DRUG ABUSE | | | PACE MAKER | | | |
| | | EMPHYSEMA | | | PAIN IN JAW JOINTS | **Y** | **N** | |
| | | EPILEPSY | | | PSYCHIATRIC PROBLEMS | | | DO YOU SMOKE OR USE TOBACCO? |
| | | FAINTING SPELLS | | | RHEUMATIC FEVER | | | **FEMALES ONLY:** |
| | | FEVER BLISTERS | | | SEIZURES | | | ARE YOU PREGNANT OR NURSING? |
| | | FREQUENT HEADACHES | | | SINUS PROBLEMS | | | ARE YOU TAKING BIRTH CONTROL PILLS? |

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

IS THERE ANY DISEASE, CONDITION OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE?

HAVE YOU EVER HAD ANY BAD EXPERIENCES AT THE DENTAL OFFICE?

IS THERE ANYTHING THAT YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

## OFFICE POLICIES AND CONSENT FOR TREATMENT

BEFORE TREATMENT CAN BE RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN.

WE USE LOCAL ANESTHETIC AND OTHER METHODS OF PAIN CONTROL TO MAKE OUR PATIENTS MORE COMFORTABLE WHILE RECEIVING DENTAL TREATMENT.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGICAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

THIS IS TO CERTIFY THAT I WAS GIVEN A COPY OF SPRINGFIELD LORTON DENTAL GROUP NOTICE OF PRIVACY PRACTICES

PRINT YOUR NAME:

| SIGNATURE OF PARENT: | DATE: |
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