CHILD REGISTRATION FORM Date_____

Section I Patient Information

NAME:_____ **PREFERRED NAME:**_____

ADDRESS:_____ **HOME PHONE NO:**_____

CITY:_____ **STATE:**____ **ZIP:**_____ **WORK PHONE NO:**_____

MOTHER'S FULL NAME:_____ **CELL PHONE NO:**_____

FATHER'S FULL NAME:_____ **EMAIL ADDRESS:**_____

GENDER: M / F **SOCIAL SECURITY NO:**_____

SCHOOL/GRADE:_____ **DATE OF BIRTH:**_____

Section II Health History

IT IS VERY IMPORTANT THAT WE KNOW ABOUT YOUR MEDICAL/DENTAL HISTORY. MANY THINGS HAVE A DIRECT BEARING ON DENTAL HEALTH/TREATMENT. ALL INFORMATION IS CONFIDENTIAL.

PHYSICIAN'S NAME:_____ PHONE NUMBER:_____

Are you currently under a physician's care? Y N (please circle one)

Reason:_____

CURRENT MEDICATIONS:_____

RECENTLY HOSPITALIZED? Y N (please circle one) REASON:_____

WOMEN: ARE YOU PREGNANT? Y N (please circle one) NURSING? Y N (please circle one)

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS.

YES	NO		YES	NO	
___	___	AIDS/HIV	___	___	HEPATITIS A / B / C (please circle one)
___	___	ABNORMAL BLEEDING	___	___	HERPES/FEVER BLISTERS
___	___	ANGINA (CHEST PAINS)	___	___	HIGH/LOW BLOOD PRESSURE
___	___	ANEMIA	___	___	KIDNEY PROBLEMS
___	___	ARTIFICIAL HEART VALVE	___	___	LIVER DISEASE
___	___	ARTIFICIAL JOINT REPLACEMENT	___	___	MITRAL VALVE PROLAPSE
___	___	ASTHMA /EMPHYSEMA	___	___	PACE MAKER
___	___	CANCER/TUMOR OR MALIGNANCY	___	___	PSYCHIATRIC CARE
___	___	CHEMO/RADIATION	___	___	REFLUX
___	___	CURRENT/PAST TOBACCO USE	___	___	RHEUMATIC/SCARLET FEVER
___	___	DIABETES	___	___	RESPIRATORY PROBLEMS
___	___	TAKING INSULIN	___	___	STROKE
___	___	EPILEPSY/SEIZURES	___	___	TUBERCULOSIS
___	___	HEART MURMUR	___	___	VENEREAL DISEASE
___	___	HEART ATTACK DATE:_____	___	___	ALLERGIC TO LATEX
___	___	STENTS PLACED	___	___	ALLERGIC TO PENICILLIN

PLEASE LIST ALL OTHER ALLERGIES OR MEDICAL CONCERNS:_____

_____

Section III Insurance Information

NAME OF POLICY HOLDER:_____ EMPLOYED BY:_____

POLICY HOLDER'S DATE OF BIRTH:_____ POLICY HOLDER'S SSN:_____

NAME OF DENTAL INSURANCE CO:_____ INSURANCE CO PHONE #:_____

DENTAL IDENTIFICATION #:_____ RELATIONSHIP TO POLICY HOLDER:_____

SECONDARY DENTAL BENEFIT PLAN (IF APPLICABLE)

NAME OF POLICY HOLDER:_____ EMPLOYED BY:_____

POLICY HOLDER'S DATE OF BIRTH:_____ POLICY HOLDER'S SSN:_____

NAME OF DENTAL INSURANCE CO:_____ INSURANCE CO PHONE #:_____

DENTAL IDENTIFICATION #:_____ RELATIONSHIP TO POLICY HOLDER:_____

Section IV Misc. Patient Information

EMERGENGY CONTACT PERSON:_____ TELEPHONE NUMBER:_____

RELATIONSHIP TO PATIENT:_____

APPROX. DATE OF LAST DENTAL X-RAYS:_____

FAMILY MEMBERS WHO ARE PATIENTS IN OUR PRACTICE:_____

_____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

- I hereby authorize Gane & Karshner DDS, Professional Association to submit claims and assign benefits, on my behalf, to my Insurance Company(s) listed above.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

*PARENT OR GUARDIAN SIGNATURE:*_____

*DATE:*_____