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PEDIATRIC & ADOLESCENT DENTISTRY

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NEW PATIENT REGISTRATION FORM

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GENERAL INFORMATION

This information is requested for financial and credit purpose.

Child's Name _____ Date of Birth _____

Name of person who is financially responsible for the child _____

MOTHER (full name) _____ Date of Birth _____ Occupation _____

Home address _____ City/State/Zip _____

Home phone _____ Work phone _____ Cell phone / Pager _____

Employer _____ Address _____ City/State/Zip _____ Phone _____

Social security number _____

FATHER (full name) _____ Date of Birth _____ Occupation _____

Home address _____ City/State/Zip _____

Home phone _____ Work phone _____ Cell phone / Pager _____

Employer _____ Address _____ City/State/Zip _____ Phone _____

Social security number _____

Child resides with: Both parents _____ Mother _____ Father _____ Other _____ (Please specify)

Person to contact in case of emergency: Name _____ Relationship to child _____

Address _____ City _____ Home phone _____ Work phone _____

INSURANCE INFORMATION

Do you have dental insurance? ___ Yes ___ No

MOTHER: Name of Insurance Company _____ Group/Policy No. _____

Address _____ Phone _____

FATHER: Name of Insurance Company _____ Group/Policy No. _____

Address _____ Phone _____

Please complete both sides.

MEDICAL INFORMATION

Child's name: _____ Age _____ Today's date: _____

Child's pediatrician _____ Phone _____

Is your child generally healthy? Yes No

What type of medical problem(s) does he/she have? _____

Does your child have a prolonged bleeding problem? Yes No

Is your child currently taking any medication? Yes No

Name(s) of the current medication(s): _____

Does your child have allergic reaction to any medication, latex or food? Yes No

Name(s) of the medication(s) or thing(s) he/she is allergic to: _____

Any other information related to your child's medical health that you think is important:

DENTAL INFORMATION

Is this your child's first dental visit? Yes No

What is the name of his/her previous dentist? _____ Phone _____

Did he/she have X-ray(s) taken at the other dentist's office? Yes No

Is there any particular dental problem that you would like to discuss with the doctor? Yes No

What is your child's dental problem that you would like to discuss? _____

Any other information related to your child's dental health that you think is important:

Please complete both sides.

Please send this form back to our office by mail or fax (650) 965-7988 before the appointment day.

We greatly appreciate your assistance.