

WELCOME

Child Dental Registration and History

Patient Information

Patient Name _____ Date _____
Last Name First Name MI (Preferred Name)

Address _____ City _____ State _____ Zip _____

Sex Male Female Birth Date _____ Social Security # _____

Phone Numbers: Home _____ Patient Cell _____

Child's Parent Information

Mother: Name _____ Birthdate _____ SS# _____
 Occupation _____ Employer _____ Work Phone _____
 Cell Phone _____ Email _____

Father: Name _____ Birthdate _____ SS# _____
 Occupation _____ Employer _____ Work Phone _____
 Cell Phone _____ Email _____

Responsible Party

Name _____ Phone number _____

Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Health History

Have you ever had any of the following? Please check all that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Iodine Allergy | <input type="checkbox"/> Rheumatic Fever |
| _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> STD |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| Date placed _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease/Condition | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Ulcers |
| Inhaler Y <input type="checkbox"/> N <input type="checkbox"/> | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | Other: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | Due Date _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |

Health History Continued

Has your child ever had any complications following dental treatment? Yes No

If yes, Please explain: _____

Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, Please explain: _____

Is your child now under the care of a physician? Yes No

If yes, Please explain: _____

Name of Physician: _____ Phone: _____

Has your child been recently been diagnosed, treated, or exposed to infections or M.R.S.A?

If yes, Please explain: _____

Does your child have any health problems that need further clarification? Yes No

If yes, Please explain: _____

List any **prescription medications your child** are taking:

Consent for Services

All emergency dental services, or any dental services without previous financial arrangements, must be paid for in cash at the time services are performed. A service charge of 18% on the unpaid balance will be charged on all accounts exceeding 90 days.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account.

However, this dental office cannot provide services on the assumption that our charges will be paid by an insurance company.

You are hereby notified if collection procedures become necessary, you may be responsible for attorney fees incurred with regard to the collection of your past due account.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have disclosed any health problems or concerns that I have and all medications that I am taking prior to signing this form.

I understand that there are certain inherent and potential risks with any procedures, the most common operative risks include, but are not limited to pain, infection, swelling, bleeding, bruising and dry socket. There can be pain, numbness or inflammation anesthetic from injection of anesthetic. In addition I understand I could experience racing of the heart and/or shortness of breath temporarily if anesthetic inadvertently enters vein or artery. If trauma/damage to the nerve occurs this could include, but is not limited to numbness of the lips; the tongue; any tissues of the mouth; and/or cheeks or face. This numbness which could occur, may be a temporary nature, lasting a few days, a few weeks, a few months, or could possibly be permanent, and could be a result of surgical procedures or anesthetic administration. By signing this form, I am giving my consent to allow and authorize Dr J. Alan Timmons and his associates to render any treatment necessary or advisable to my dental conditions, including any and all anesthetics and/or medications.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient _____