KIDSHINE PEDIATRIC DENTAL GROUP

Patient Registration Form

Patient (Your Child's) Registration Update

Child's Name _____ Preferred / Nickname _____

Gender: Male____ Female____ School_____

Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Patient's Mother's / Guardian's Information

Name _____ Date of Birth _____

Social Security Number_____ Marital Status _____ Occupation _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ **Cell Phone** _____

e-mail _____

Patient's Father's / Guardian's Information

Name _____ Date of Birth _____

Social Security Number_____ Marital Status _____ Occupation _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ **Cell Phone** _____

e-mail _____

Patient's Primary Dental Insurance Information

Subscriber's Name _____ Name of Insurance Co. _____

ID# _____ Employer _____

Patient's Secondary Insurance Information

Subscriber's Name _____ Name of Insurance Co. _____

ID# _____ Employer _____

Name of Closest Relative _____ **Relationship** _____

Home Address _____

Home Phone _____ Work Phone _____

Military Personnel Only: Rank _____

_____

Person Responsible for Billing_____ **Relationship** _____

Billing Address _____

Home Phone _____ Work Phone _____

Name of Physician _____ **Physician's Phone** _____

Name of Former Dentist_____ **Date of Last Dental Visit** _____

Whom may we thank for referring you here _____

HEALTH HISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
ANEMIA	____	____			
ASTHMA	____	____			
CANCER	____	____			
HEPATITIS	____	____	HANDICAPS / DISABILITIES	____	____
HIV / AIDS	____	____	TUBERCULOSIS	____	____
HEMOPHILIA	____	____	DIABETES	____	____
ABNORMAL BLEEDING	____	____	RHEUMATIC FEVER	____	____
ALLERGIES	____	____	CONGENITAL HEART DEFECT	____	____
ALLERGIES TO PENICILLIN	____	____	HEART MURMUR	____	____
ALLERGIES TO ANESTHETIC	____	____	CONVULSIONS / EPILEPSY	____	____

PLEASE EXPLAIN ANY MEDICAL PROBLEMS THAT YOUR CHILD HAS _____

_____

_____

CHILD'S HABIT

HOW OFTEN DOES YOUR CHILD BRUSH? _____

HOW OFTEN DOES YOUR CHILD FLOSS? _____

DOES YOUR CHILD:	YES	NO
SUCK THUMB / FINGER	____	____
SUCK / BITE LIPS	____	____
BITE / CHEW NAILS	____	____
CHEW HARD OBJECTS (PENCILS, ETC.)	____	____
GRIND TEETH	____	____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the Dental Office of any changes in my child's medical status.

I also authorize the Dental Staff to perform the necessary dental services my child may need.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN _____ **DATE** _____

I authorized the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to the insurance company to pay directly to the Dentist or Dental Group insurance benefits otherwise payable to me.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN _____ **DATE** _____

Payments of all dental fees is the primary responsibility of the Patient/Parent. All such payments shall be made directly to our Office. We will be happy to assist in preparing the necessary forms to help collect benefits from insurance companies, but it shall be the ultimate and primary responsibility of the Patient/Parent to submit the necessary forms and secure any benefits that may be due.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf on my dependents.

In the event of non-payment from the insurance companies the undersigned agrees to pay all the costs of the dental service rendered.

SIGNATURE OF PARENT OR RESPONSIBLE GUARDIAN _____ **DATE** _____