Kpd Keystone Pediatric Dentistry

MINOR/CHILD REGISTRATION
Please Print

3591 Reserve Commons Drive, Suite 200
Medina, OH 44256
Telephone: (330) 723-7566

PATIENT INFORMATION

Name of Minor/Child _____
(Last Name) (First Name) (Initial)

Sex_____M ☐ F ☐ Age_____ Birthdate _____ Hobbies _____

Home Address _____
Street City State ZIP

Mailing Address _____
Street City State ZIP

Person accompanying patient_____Home Phone _____ Work Phone _____

Cell Phone Number_____ E-Mail Address _____

Whom may we thank for referring you _____

PARENT GUARDIAN INFORMATION *(must be completed)*

Father's/Guardian's Name_____

Address (if different from patient's) _____

Home Phone_____Work Phone _____
(If different from above)

Employer _____

Soc. Sec. #_____Birthdate _____

Dental insurance for minor/child? ☐ Yes ☐ No

Plan Name_____

Phone No._

Address _____

Group # _____

Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone_____Work Phone _____
(If different from above)

Employer _____

Soc. Sec. # _____ Birthdate_____

Dental insurance for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____

Policy # _____

EMERGENCY CONTACT OTHER THAN PARENTS

In the event of an emergency, whom should we contact?

Name_____Relationship_____ Phone_____

Name_____ Relationship _____ Phone _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service _____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is flouride taken in any form?	☐	☐
Does parent assist child with brushing teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day	☐	☐	Any unhappy dental experiences?	☐	☐
Has your child had tonsils/adenoids removed?	☐	☐			

Any mouth habits - thumbsucking, mouth breathing, pacifier, sleeping with bottle, etc.? _____

(Continued)

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO	
Is your child up to date on immunizations against childhood diseases?	☐	☐	_____
Has your child been diagnosed with a bleeding disorder?	☐	☐	_____
Has your child ever had a reaction or problem with anesthetic?	☐	☐	_____
Is minor/child under care of physician now? _____	☐	☐	Medications _____
Receiving any medications or drugs? _____	☐	☐	_____
Ever been hospitalized? _____	☐	☐	For what? _____
Date _____	☐	☐	Where _____
Ever had surgery? _____	☐	☐	For What? _____
Date _____	☐	☐	Where _____
Is there excessive bleeding when cut? _____	☐	☐	Allergies? _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? *(If so, please check!)*

☐ ADD/ADHD	☐ Cerebral Palsy	☐ Heart Disease	☐ Seizures
☐ AIDS/HIV	☐ Chicken Pox	☐ Heart Murmur	☐ Sinus Problems
☐ Amoxicillin Allergy	☐ Cystic Fibrosis	☐ Hepatitis	☐ Speech Delay
☐ Anemia	☐ Developmentally Delayed	☐ Kidney Disease	☐ Stomach Problems
☐ Aperts Syndrome	☐ Diabetes	☐ Latex Allergy	☐ Stroke
☐ Artificial Joints	☐ Downs Syndrome	☐ Liver Disease	☐ Sulfa Allergy
☐ Aspergers Syndrome	☐ Drug/Alcohol Abuse	☐ Measles	☐ Thyroid Disease
☐ Asthma	☐ Emotional or Psychiatric Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Autism	☐ Epilepsy	☐ Mumps	☐ Ulcers
☐ Behavioral Problems	☐ Excessive Bleeding	☐ Muscular Dystrophy	☐ Zithromax Allergy
☐ Bladder Problems	☐ Fainting	☐ Penicillin Allergy	☐ Others
☐ Brain Shunt	☐ Hearing Problems	☐ Radiation Treatment	
☐ Cancer	☐ Hearing Loss	☐ Rheumatic Fever	

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my resposibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child. I am responsible for all charges regardless of personal financial agreements between parents.

_____ _____

Signature of Parent/Guardian Date

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____ and I assign directly to Keystone Pediatric Dentistry Sally Lauterjung D.D.S. INC. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian Date