

HERITAGE FAMILY DENTAL - REGISTRATION AND HISTORY

PATIENT INFORMATION

Date: _____

Patient Name: _____

Preferred Name: _____

Sex: M F Date of Birth: _____

Legal Parent/Guardian: _____

Relationship to Patient: _____

Address: _____

City: _____ Zip: _____

Phone – Home: _____

Cell: _____

Work: _____ Ext: _____

Can you be reached at work? Yes No

Email: _____

Patient School: _____

Full Time Part Time

Address: _____

City: _____ Zip: _____

How did you hear about us? _____

EMERGENCY NUMBER

(Specify someone who does not live in household)

Name: _____

Phone – Home: _____

Work/Cell: _____

Relationship: _____

DENTAL HISTORY

Reason for today's visit: _____

Former Dentist: _____

City/State: _____

Phone #: _____

Date of last Dental Visit: _____ Dental X-rays: _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Has your child had difficulty associated with any previous dental treatment? Yes No
If yes, please explain: _____

ORAL HABITS:

Does your child have any oral habits? Yes No

If yes, please explain: _____

Does your child clench or grind? Yes No

ORAL DEVELOPMENT:

Has your child needed frequent use of liquid antibiotics? Yes No

Child's age when first tooth erupted? _____

DENTAL INSURANCE

Subscriber's Name: _____

Birthdate: _____ SS#: _____

Relationship to patient: _____

Employer: _____

Insurance Co.: _____

Group #: _____

Does patient have additional insurance? Yes No

Subscriber's Name: _____

Birthdate: _____ SS#: _____

Relationship to patient: _____

Employer: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

Unless prior arrangements have been made

If this office accepts insurance, I understand that I am responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to Heritage Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of my information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I have received a copy of this office Notice of Privacy Practices.

Signature of Parent/Personal Representative _____

Date _____

Has your child experienced teeth problems? Yes No

If yes, please explain: _____

Has your child had any injuries to his/her mouth? Yes No

Has your child ever had orthodontic treatment (retainers/braces)? Yes No

When: _____ Doctor's Name: _____

ORAL HYGIENE:

Do you clean your child's teeth/gums? Yes No

Do you use a toothbrush to clean your child's teeth? Yes No

Do you use toothpaste to clean your child's teeth? Yes No

Does your child's gum bleed when brushing? Yes No

DIET AND NUTRITION:

Is/was your child breastfed? Yes No

Does your child sleep with a bottle? Yes No

Does your child drink from a sippy cup? Yes No

Is your child on a special diet? Yes No

FLUORIDE ADEQUACY:

Do you have well water? Yes No

Has it been tested for fluoride? Yes No

