Andrew Hoffman DMD

CHILD REGISTRATION AND HEALTH HISTORY

We would like to welcome your child to our office. Our goals are to make each visit pleasant and educational and to help your child achieve and maintain optimal oral health. In order to serve your child properly, it is necessary for us to obtain the following information and maintain its currency.

Today's Date ____/____/____

PATIENT INFORMATION

First Name _____ Last Name _____ M.I. ___ Preferred Name _____
Sex: ❍ M ❍ F DOB ____/____/____ Age _____ Soc. Sec. # _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ School _____ Grade _____
List special interests, sports, or hobbies: _____
_____
Siblings (names and ages) _____
Whom may we thank for referring your child? _____

PARENTAL/GUARDIAN INFORMATION

❍ Mother ❍ Step Mother ❍ Guardian
First Name _____ Last Name _____ M.I. ___ DOB ____/____/____ Soc. Sec. # _____
Your Home Address and Phone (if different from child's):
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Ext. _____ Cell Phone (____) _____
Preferred Phone Number: ❍ Home ❍ Work ❍ Cell E-mail Address _____
Employer _____ Occupation _____ How long there? _____
Employer's Address _____ City _____ State _____ Zip _____

❍ Father ❍ Step Father ❍ Guardian
First Name _____ Last Name _____ M.I. ___ DOB ____/____/____ Soc. Sec. # _____
Your Home Address and Phone (if different from child's):
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Ext. _____ Cell Phone (____) _____
Preferred Phone Number: ❍ Home ❍ Work ❍ Cell E-mail Address _____
Employer _____ Occupation _____ How long there? _____
Employer's Address _____ City _____ State _____ Zip _____

Person Responsible for this Account _____ Relationship to Patient _____

EMERGENY CONTACT INFORMATION (Other than Parent/Guardian)

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Primary Phone (____) _____ ❍ Home ❍ Work ❍ Cell Alternative Phone (____) _____ ❍ Home ❍ Work ❍ Cell

DENTAL INSURANCE INFORMATION

Dental Coverage? ❍ Yes ❍ No If yes, complete the following:
Primary Insurance Company Name _____
Insurance Company Address _____ City _____ State _____ Zip _____
Insurance Company Phone Number (____) _____ ID# _____
Group Name _____ Group# _____ Policy Holder's Name _____
Relationship to Patient _____ DOB ____/____/____ Soc. Sec. # _____ Employer _____
Secondary Insurance Company Name (if applicable) _____
Insurance Company Address _____ City _____ State _____ Zip _____
Insurance Company Phone Number (____) _____ ID# _____
Group Name _____ Group# _____ Policy Holder's Name _____
Relationship to Patient _____ DOB ____/____/____ Soc. Sec. # _____ Employer _____

MEDICAL HISTORY

Is your child currently under the care of a physician? ❍ Yes ❍ No Reason _____

Physician's Name _____ City _____ State _____ Phone # (_____) _____

Date of your child's last physical exam/visit ____ /____/ ____ Your child's current physical health is: ❍ Excellent ❍ Good ❍ Fair ❍ Poor

Are your child's immunizations current? ❍ Yes ❍ No Please list any surgeries/hospitalizations (include dates): _____

_____

Does your child have a history of any of the following?

ADD/ADHD	❍ Yes ❍ No	Developmental Delay	❍ Yes ❍ No	Liver Problems	❍ Yes ❍ No
AIDS/HIV Positive	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No
Alcohol/Drug Use	❍ Yes ❍ No	Ear Aches	❍ Yes ❍ No	Lupus	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Eating Disorder	❍ Yes ❍ No	Measles	❍ Yes ❍ No
Artificial Bones/Joints/Valves	❍ Yes ❍ No	Epilepsy	❍ Yes ❍ No	Mental Health Disorders	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Fainting Spells/Dizziness	❍ Yes ❍ No	Mononucleosis	❍ Yes ❍ No
Autism	❍ Yes ❍ No	Frequent Headaches/Migraines	❍ Yes ❍ No	Mumps	❍ Yes ❍ No
Bleed/Bruise Easily	❍ Yes ❍ No	Gastrointestinal Problems	❍ Yes ❍ No	Rheumatic Fever	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Growth Problems	❍ Yes ❍ No	Scarlet Fever	❍ Yes ❍ No
Date(s): _____		Handicaps /Disabilities	❍ Yes ❍ No	Sickle Cell Disease	❍ Yes ❍ No
Brain Injury	❍ Yes ❍ No	Hay Fever/Allergies	❍ Yes ❍ No	Sinus Problems	❍ Yes ❍ No
Cancer/Chemotherapy/Radiation	❍ Yes ❍ No	Hearing Impairment	❍ Yes ❍ No	Speech Problems	❍ Yes ❍ No
Specify: _____		Heart Murmur	❍ Yes ❍ No	Thyroid Condition	❍ Yes ❍ No
Cerebral Palsy	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No	Tobacco Use	❍ Yes ❍ No
Chicken Pox	❍ Yes ❍ No	Hepatitis Type_____	❍ Yes ❍ No	Tonsillitis	❍ Yes ❍ No
Cleft Lip/Palate	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Congenital Heart Defect	❍ Yes ❍ No	Hives/Skin Rash	❍ Yes ❍ No	Visual Impairment	❍ Yes ❍ No
Convulsions/Seizures	❍ Yes ❍ No	Kidney Problems	❍ Yes ❍ No		

Please list any other serious medical condition(s) that your child has ever had:

What pharmacy do you use most regularly? _____

Location _____ Phone # (_____) _____

Medications and Drug Allergies

Is your child taking any prescription/over-the-counter medications? ❍ Y ❍ N

Please complete the following table regarding your child's current prescription and non-prescription medications:

Medication	Dosage and Frequency	Purpose

Is your child allergic, or has he/she had an adverse reaction to any of the following?

Aspirin	❍ Yes ❍ No	Jewelry/Metals	❍ Yes ❍ No	Penicillin	❍ Yes ❍ No
Latex	❍ Yes ❍ No	Sulfa Drugs	❍ Yes ❍ No	Tetracycline	❍ Yes ❍ No
Dental Anesthetics	❍ Yes ❍ No	Iodine	❍ Yes ❍ No	Ampicillin	❍ Yes ❍ No

Please list any other medications or antibiotics your child is allergic to:

Please list any allergies other than drug allergies for your child:

DENTAL HISTORY

Is this your child's first dental visit? ❍ Y ❍ N If no, complete the following:
Previous Dentist _____ City _____ State _____
Date of Last Visit ____ /____/ ____ Date of Last X-rays ____ /____/ ____

Why has your child come to the dentist today? _____

_____

Is your child currently in pain? ❍ Y ❍ N For how long? _____
Does your child require antibiotics before dental treatment? ❍ Y ❍ N
If yes, please explain: _____
Has your child ever had any problems with dental treatment in the past? ❍ Y ❍ N
If yes, please explain: _____
At what age did your child stop bottle feeding? Age _____ Breast Feeding? Age _____
Has your child had any problems with the eruption of teeth? ❍ Y ❍ N
Does your child have any missing or extra permanent teeth? ❍ Y ❍ N
Has your child ever had any orthodontic treatment? ❍ Y ❍ N
Has your child ever had an injury to (select all that apply): ❍Teeth ❍Mouth ❍ Jaw /Chin
Has your child ever experienced jaw joint pain/discomfort (TMJ/TMD)? ❍ Y ❍ N
How many times are your child's teeth brushed per day? _____
How many times are your child's teeth flossed per day? _____
Is your child's home water supply fluoridated? ❍ Y ❍ N
Does your child take fluoride supplements? ❍ Y ❍ N
Does your child use a fluoride toothpaste? ❍ Y ❍ N
Is your child interested in teeth whitening (age 14 and over)? ❍ Y ❍ N

Does your child currently or has your child ever had any of the following habits? *(check all that apply)*

❑ Chewing on Objects ❑ Lip Sucking/Biting ❑ Nail Biting ❑ Finger Sucking ❑ Tongue Thrust
❑ Clenching/Grinding Teeth ❑ Mouth Breather ❑ Thumb Sucking ❑ Tongue/Cheek Biting ❑ Using Pacifier

Is there anything else you would like us to know about your child's dental health or previous dental treatment?

_____

_____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

AUTHORIZATION AND RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform Dr. Hoffman of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. If Dr. Hoffman accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Andrew Hoffman DMD 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 any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X Signature of Parent/Guardian: _____ Date: ____ /____/ ____

FOR OFFICIAL USE ONLY

Reviewed by: _____ Date: ____ /____/ ____