Walnut Hills
PEDIATRIC DENTISTRY

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# Patient Registration Form

## Patient Information

Last Name _____ First Name _____ Middle Initial _____ Sex _____

Prefers to be addressed by _____ Date of Birth ____ /____ /____ Age (years) _____

Address _____ Apt. # _____

City _____ State _____ Zip _____ Home Telephone _____ Cell Phone # _____

Other family members treated at this office _____

## Parental Information

| Mother | Father |
|---|---|
| Name _____ | Name _____ |
| Date of Birth ____ /____ /____ | Date of Birth ____ /____ /____ |
| Social Security # _____ | Social Security # _____ |
| E-mail Address _____ | E-mail Address _____ |
| ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Guardian | ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Guardian |
| Employer _____ | Employer _____ |
| Employer Address _____ | Employer Address _____ |
| Employer Telephone _____ | Employer Telephone _____ |
| Complete if **DIFFERENT** from patient's home information: | Complete if **DIFFERENT** from patient's home information: |
| Home Address _____ | Home Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Home Telephone _____ Cell _____ | Home Telephone _____ Cell _____ |

## Dental Insurance Information

(Please provide your insurance card to the receptionist)

| Primary Insurance | Secondary Insurance |
|---|---|
| Company _____ | Company _____ |
| Address _____ | Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Insurance Telephone _____ | Insurance Telephone _____ |
| Policy / Group # _____ | Policy / Group # _____ |
| Policy Holder's Name _____ | Policy Holder's Name _____ |
| Relationship to Patient _____ | Relationship to Patient _____ |

## Referral Information

How did you hear about us? ☐ Dentist ☐ Family ☐ Friend ☐ Pediatrician ☐ School Presentation ☐ Web Site ☐ Yellow Pages ☐ Other

Name of person to thank for referral _____

## Dental History

1. Previous dentist (If any)_____ Date of last dental exam_____
2. When, if ever, were x-rays taken?_____ Where? _____
3. What concerns you most about your child's dental health?

_____

4. Does your child ever have dental pain? If so, where?

_____

5. Is your child developing mentally and socially as his/her age would indicate?_____
6. Mouth habits (Please check): ☐ Thumb Sucking ☐ Pacifier ☐ Mouth breathing
   ☐ Finger habit ☐ Tooth grinding ☐ None ☐ Still on bottle
7. Did your child ever have a negative dental experience?_____
   Discuss _____
8. Has the child had teeth removed? _____
9. How often does your child brush? _____ Floss? _____ Use Flouride Toothpaste?_____
10. Has the child received any fluoride treatment? _____ Amount _____
11. Do you have: City Water? ☐ Well Water? ☐
12. Has your child received fluoride supplements? ☐ Yes ☐ No
13. Are they still receiving fluoride supplements? ☐ Yes ☐ No
12. Are you happy with the appearance of your child's teeth? _____
13. Has your child or any family member had a history of temporal mandibular joint disorder (TMJ)? _____
    If so, describe _____

## Medical History

1. Is the patient's general health good at this time? ☐ Yes ☐ No
2. Name of physician? _____ Date of last physical: _____
3. Is the patient under the care of a physician at this time? ☐ Yes ☐ No
   Explain: _____
4. Is the patient taking any medication? ☐ Yes ☐ No If yes, what: _____
5. Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) ☐ Yes ☐ No
   If yes, what: _____
6. Does the patient have any other allergies (metals, latex, seasonal etc.)? ☐ Yes ☐ No
   If yes, what: _____
7. Has the patient had tonsils and adenoids removed? ☐ Yes ☐ No Date: _____
8. Has the patient ever had a serious illness or been hospitalized? ☐ Yes ☐ No Date: _____
   Explain: _____
9. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? ☐ Yes ☐ No
   If yes, antibiotic name and method: _____
10. Has the patient reached puberty? ☐ Yes ☐ No
11. Is there any other information that should be known about your child's health? _____
12. Please check all conditions the patient has now or has ever had:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Birth Defects | ☐ | ☐ | Prosthetic (artificial) Joint | ☐ | ☐ | Blood Disorders/Bleeding Problems | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | Hearing/Sight Impaired | ☐ | ☐ | X-Ray/Radiation (cancer) Therapy | ☐ | ☐ | Blood Transfusions | ☐ | ☐ | Psychiatric Treatment |
| ☐ | ☐ | Endocarditis | ☐ | ☐ | AIDS or H.I.V. Positive | ☐ | ☐ | Sickle Cell | ☐ | ☐ | Headaches |
| ☐ | ☐ | Heart Condition | ☐ | ☐ | Diabetes | ☐ | ☐ | Arthritis | ☐ | ☐ | Earaches |
| ☐ | ☐ | Heart Pacemaker | ☐ | ☐ | Respiratory Lung Disease | ☐ | ☐ | Ulcers | ☐ | ☐ | Jaw Clicking |
| ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | Hepatitis (type?_____ | ☐ | ☐ | Anemia | ☐ | ☐ | Allergies |
| ☐ | ☐ | Congenital Heart Disease | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Asthma | ☐ | ☐ | Jaw Pain |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Developmental Delayed | ☐ | ☐ | Epilepsy (seizures) | ☐ | ☐ | Tonsillitis |
| ☐ | ☐ | Heart Surgery date:_____ | ☐ | ☐ | Learning Delayed | ☐ | ☐ | Fainting Spells | ☐ | ☐ | Emotional Problems |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | ADD | ☐ | ☐ | Kidney Trouble | | | |
| ☐ | ☐ | Rheumatic Fever | | | | | | | | | |
| ☐ | ☐ | Other: _____ | | | | | | | | | |

I request and authorize Dr. Nicholas Waage to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Waage to diagnose and/or treat my child's dental problems. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Waage will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Parent/Guardian Signature_____ Date _____

Please send your completed form to patientforms@walnuthillsdentistry.com.
Note: If you are sending this form by email to Dr. Waage, you will be asked to sign it at your first appointment. If you choose not to email this form, please print, sign and bring it with you to your appointment.