pediatric dental care Smiles

Caroline W. Larosiliere, D.D.S.
Pediatric Dentist

PATIENT REGISTRATION FORM

Thank you for choosing our office.
We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Patient ID # _____
Today's Date: _____

Your Child:

Patient Name: _____ Gender: _____ Age: _____
Nickname: _____ SS#/SIN: _____ Birthdate: _____
School: _____ Grade: _____
Child's Home Address: _____
City: _____ State: _____ Zip/P.C. _____ Home Phone: _____

Responsible Party:

Name: _____ Relationship: _____
Home Address: _____ E- mail: _____
City: _____ State: _____ Zip/P.C. _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
SS#/SIN: _____ DL#: _____
Who is responsible for making appointments? _____

Parent or Guardian Information: ☐ Mother ☐ Stepmother ☐ Guardian
Name: _____ E-mail: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
SS#/SIN: _____ DL#: _____
Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

Parent or Guardian Information: ☐ Father ☐ Stepfather ☐ Guardian
Name: _____ E-mail: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
SS#/SIN: _____ DL#: _____
Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

Primary Insurance

Insured Name: _____ Relationship: _____
Birth Date: _____ SS#/SIN: _____
Employer: _____ Date Employed: _____ Occupation: _____
Insurance Co.: _____ Group #: _____ Employee #: _____
Ins. Co. Address: _____ City: _____ State/Prov: _____ Zip/P.C.: _____
Deductible: _____ Copay: _____ Amount already used: _____ Max annual benefit: _____

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Dental/Medical Health History (Confidential)

Patient ID #

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush?

How often does your child floss?

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck Thumb/Fingers	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of last dental visit

Previous Dentist

Address

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever taken Fen Phen/Redux? ☐ Yes ☐ No

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐ Yes	☐ No

Child's Primary Care Physician Phone Number

Address

Previous Hospitalizations/Surgeries/Serious Illnesses When?

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list)

Does your child have a history of allergies/sensitivities/adverse reactions to medications (Penicillin, Novocain, etc)? ☐ Yes ☐ No

(if yes, please describe)

Does your child have a history of allergies to any other substances (latex, environmental, etc)? ☐ Yes ☐ No

(if yes, please describe)

Please explain any other medical problems that your child have:

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. ☐ Cash ☐ Personal Check Credit Card: ☐ Visa ☐ MasterCard ☐ I wish to discuss the offices payment policy

AUTHORIZATION & RELEASE

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. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my 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 or my dependents.

Signature