

PATIENT REGISTRATION

Patient Name: _____ Today's Date : _____

Date of birth: _____ Age: _____ Male/Female: _____ Social Security Number: _____ - _____ - _____

Address: _____ City _____ St _____ Zip _____

Home Phone Number: (____) _____ Work Phone Number: (____) _____

Status (Circle One): Single, Married, Divorced, Separated, Widowed

Email Address _____

Employer Name and Address : _____

Present Position _____

Whom may we thank for referring you? _____

Name of Spouse, Parent or Custodian: _____

Date of birth: _____ Age: _____ Male/Female: _____ Social Security Number: _____ - _____ - _____

Email address : _____

Home Phone Number: (____) _____ Work Phone Number: (____) _____

Spouse's Employer Name and Address _____

Emergency Contact Person _____

Emergency Contact's Address _____

Emergency Contact's Home Phone Number: (____) _____

Emergency Contact's Work Phone Number: (____) _____

Primary Dental Insurance Co : _____

(Name) (Address)

Name of Policy Holder: _____ Group or ID # : _____

Secondary Dental Insurance Co : _____

(Name) (Address)

Name of Policy Holder: _____ Group or ID # : _____

Person Responsible for this Account : _____

I hereby authorize Dr. Alan Litvinov and his team to perform dental treatment which may include the use of local anesthesia, nitrous sedation, x-rays or diagnostic tests. I understand that, though good results are expected, the possibility and nature of complications such as swelling, infection, discoloration of the face or neck, bruising, muscle or TMJ soreness, or difficulty swallowing cannot always be accurately anticipated.

Signature of Patient, Parent or Guardian: _____ Date: _____

Patient name _____

Date of Birth ____/____/____ Parent's Name _____

MEDICAL HISTORY

Name of child's physician _____ Date of last physical exam ____/____/____

Physician's address _____ Physician's phone number _____

Does your child have any CURRENT HEALTH PROBLEMS? No Yes

Is your child under a physician's care now? (if Yes, see below) No Yes
If yes, for what? _____

What MEDICATIONS is your child currently taking? (if any, list below)
Medications: _____

Has your child ever had a serious illness, operation, or hospitalization? No Yes
If so, for what? _____ When? _____

CIRCLE ANY OF THE FOLLOWING YOUR CHILD HAS HAD, OR PRESENTLY HAS:

- | | | | |
|---------------------|--------------------|-------------------------|----------------|
| Rheumatic Fever | Anemia | Hepatitis/Liver Disease | Hemophilia |
| Heart Disease | Tuberculosis | Brain Injury | Transfusions |
| Heart Murmur | Lung Disease | Seizures | Tumors/Growth |
| High Blood Pressure | Asthma | Speech Disorder | Kidney Disease |
| Sickle Cell | Allergies or Hives | Emotional Disorder | Other: _____ |
| Disease/Trait | Diabetes | Bleeding Disorder | |
| Blood Disease | | | |

IS YOUR CHILD ALLERGIC TO OR HAS HE/SHE REACTED ADVERSLY TO ANY OF THE FOLLOWING:

- | | | | |
|---------|------------------|--------------|----------|
| Aspirin | Nitrous Oxide | Penicillin | Codeine |
| Tylenol | Local Anesthetic | Erythromycin | Sedative |
- Other medicines or substances? _____

DENTAL HISTORY

How long since your last dental visit? _____ Date of last FULL MOUTH X-RAYS: ____/____/____

Date of last COMPLETE dental exam: ____/____/____

What is your child's present dental health? (Circle one) POOR AVERAGE EXCELLENT

Any INJURIES to teeth, mouth or head? No Yes

Are you or your child having a PROBLEM now? No Yes

If Yes, explain: _____

Any oral habits? (Circle those that apply) THUMBSUCKING NAILBITING MOUTHBREATHING

Has your child ever taken a BOTTLE at nap or bedtime? No Yes

Is this your child's FIRST visit to the dentist? No Yes

Has your child had an UNHAPPY dental or medical visit? No Yes

What is your child's attitude towards dentistry? (Circle one) POSITIVE NEGATIVE

Summary of dental history: _____

To the best of my knowledge, the above questions have been answered accurately. I hereby consent to the initial examination, including the taking of diagnostic radiographs (x-rays), photographs and casts as deemed necessary by Dr. Alan Litvinov

_____ Date _____ Signature of parent/guardian _____

FOR DOCTOR'S USE ONLY

Summary of medical history/medical problems affecting dental treatment _____

Remarks _____

Hx obtained from _____

Doctor's signature _____ Date ____/____/____