

CHILD

REGISTRATION HISTORY

DATE _____

PATIENT'S NAME _____

NICKNAME _____ BIRTHDATE _____ M/F _____

PARENT/LEGAL GUARDIAN _____ HM PH _____ CELL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT EMPLOYED BY _____ WK PH _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

PARENT'S SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

EMERGENCY CONTACT (Other than parent) NAME _____

ADDRESS _____ PHONE _____

RELATIONSHIP TO PATIENT _____

WHOM MAY WE THANK FOR REFERRING YOU _____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR SERVICES? YES _____ NO _____

PATIENT'S PRIMARY CARRIER _____ GROUP NUMBER _____

SUBSCRIBER'S NAME _____ B/DATE _____ SS# _____

SUBSCRIBER EMPLOYED BY _____

CARRIER ADDRESS _____ CITY _____ STATE _____ ZIP _____

I authorize release of information relating to treatment received by F. Mike Farley, DDS/David C. Mace, DDS. I understand that I am responsible for all costs of treatment.

I hereby authorize payment directly to F. Mike Farley, DDS/David C. Mace, DDS of group insurance benefits otherwise payable to me.

parent/legal guardian signature

parent/legal guardian signature

PATIENT'S SECONDARY CARRIER _____ GROUP NUMBER _____
(company name)

SUBSCRIBER'S NAME _____ B/DATE _____ SS# _____

SUBSCRIBER EMPLOYED BY _____

CARRIER ADDRESS _____ CITY _____ STATE _____ ZIP _____

I authorize release of information relating to treatment received by F. Mike Farley, DDS/David C. Mace, DDS. I understand that I am responsible for all costs of treatment.

I hereby authorize payment directly to F. Mike Farley, DDS/David C. Mace, DDS of group insurance benefits otherwise payable to me.

parent/legal guardian signature

parent/legal guardian signature

Please be advised that we require 24 hours notice for cancelling an appointment, otherwise there may be a charge for the time reserved.

MEDICAL HISTORY

Have you now or ever had any of the following diseases or conditions? Are you Allergic to any of the following ?

		NO	YES			NO	YES
(PLEASE CHECK)				(PLEASE CHECK)			
Heart Trouble or Rheumatic Fever	_____	_____	_____	Penicillin	_____	_____	_____
Bleeding Trouble	_____	_____	_____	Sulfa	_____	_____	_____
Anemia	_____	_____	_____	Codeine	_____	_____	_____
High Blood Pressure	_____	_____	_____	Local Anesthetic	_____	_____	_____
Diabetes	_____	_____	_____	Aspirin	_____	_____	_____
T. B. (Tuberculosis)	_____	_____	_____	Other Drugs	_____	_____	_____
Asthma	_____	_____	_____	Are You at this Time Under the			
Nervous Disorder	_____	_____	_____	Care of a Physician?	_____	_____	_____
Hepatitis (Jaundice)	_____	_____	_____				
Kidney - Gastro Intestinal	_____	_____	_____	If So, for What?	_____	_____	_____
Glaucoma	_____	_____	_____				
Aids/HIV	_____	_____	_____	Name of your Physician	_____	_____	_____

Do you use tobacco products? _____ Have you ever had any type of venereal disease? _____

Do you use alcohol? _____ Have you ever had joint replacement surgery? _____
 If yes, how much & how often? _____ If yes which joint & when? _____

Have you had trouble with prolonged bleeding? _____ When was your last medical examination? _____

Please describe any current medical treatment - including drugs, impending operations, pregnancies, or other information the doctor should be aware of: _____

Are you now taking drugs _____ high blood pressure med. _____ cortisone or steroids _____
 sedatives or tranquilizers _____ blood thinners _____ birth control _____ other _____

DENTAL HISTORY

Are you having discomfort at this time? _____

When was your last visit to a dentist? _____

Would you like whiter teeth? _____

Would you be interested in a scientific cure for bad breath? _____

		NO	YES			NO	YES
On your previous dental visit:				Do you have a history of:			
Were you given a local anesthetic	_____	_____	_____	Headaches	_____	_____	_____
Were x-rays taken	_____	_____	_____	Pain in your jaws or ears	_____	_____	_____
Were home care instructions given	_____	_____	_____	Clicking or popping jaw joints	_____	_____	_____
Were regular preventive visits made	_____	_____	_____	Dizziness or light-headedness	_____	_____	_____
Did you have any decay	_____	_____	_____	Biting hard objects	_____	_____	_____
Were there any special problems	_____	_____	_____	Food collecting between teeth	_____	_____	_____
If so what?	_____	_____	_____				

Is there sensitivity in your mouth to: Heat _____ Cold _____ Sweets _____ Chewing _____

I hereby authorize treatment for my Dental Health Care.

Signature _____