Specialists in Toddlers, Children & Adolescents

Dr Joel R Clark, DDS &
Dr Trevor M Jensen, DDS

PATIENT REGISTRATION FORM

TELL US ABOUT YOUR CHILD

Child's Last Name:_____First_____Nickname: _____ □ Male □ Female
Child's Birth Date:_____Child's Age: _____School:_____Grade: _____
Child's Street Address: _____City_____Zip Code_____
Child's Home Number:_____
Do you have any other children who are not patients that would benefit from our services? Yes or No
Please list their name(s) & age: _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name:_____Relation:_____Do you have legal custody of the child? □ Yes □ No
In case of emergency, contact (name and phone #): _____
Whom may we thank for this referral? _____

PERSON RESPONSIBLE FOR ACCOUNT

Father's Information: **Mother's Information:**

Name:_____Date of Birth: _____Name:_____Date of Birth: _____
Address: _____Address: _____
_____
Employed By: _____Employed By: _____
Occupation: _____Occupation:_____
SS#: _____SS#:_____
Driver's License #:_____Driver's License #:_____
1st Phone #: _____1st Phone #:_____
2nd Phone #:_____ 2nd Phone #: _____
Email: _____Email: _____

Parent Marital Status: ____Married, ____Divorced, ____Single

DENTAL INSURANCE COMPANY

Insurance Co. Name: _____
Insurance Co. Address: _____Subscriber ID #: _____
Insurance Co. Phone:_____ Group # (plan, local, or policy #): _____
Insured's Name:_____ Relationship to Child: _____
Insured's Birth Date:_____SS#:_____Insured's Employer: _____
Secondary Company_____Address _____
Policy # _____ Group # _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Joel R. Clark and Dr Trevor M Jensen, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill or services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

_____

SIGNATURE OF PARENT/GUARDIAN DATE

OVER→

Child's Name_____

PLEASE PROVIDE DETAILS ON ALL "YES" RESPONSES BELOW:

MEDICAL HISTORY

1. Is your child under care of a physician? □ Yes □ No
   If □ Yes, since when and why?_____
2. Name of physician _____
3. Is your child taking any prescription medications? □ Yes □ No
   a. List current medications _____
4. Is your child taking any over the counter medications? □ Yes □ No
   a. List current medications _____
   _____
5. Does your child have seasonal allergies? □ Yes □ No
6. Does your child have any allergies to Food? □ Yes □ No
   a. Please list _____
7. Is your child allergic to any materials? □ Yes □ No
   a. Please list _____
8. Is your child allergic to any drugs, such as penicillin? □ Yes □ No
   a. Please list _____
9. Does your child have other allergies? □ Yes □ No
   a. Please list _____
10. Has your child had any serious illness? □ Yes □ No
11. Has your child ever had surgery or been hospitalized? □ Yes □ No
12. Has your child had a history of any of the following? Please check a response for each question:

Autism	□ Yes □ No
Heart trouble, murmur, or surgery	□ Yes □ No
Rheumatic fever or scarlet fever	□ Yes □ No
Asthma, TB, or lung problems	□ Yes □ No
HIV *infection* or AIDS	□ Yes □ No
Hemophilia or bleeding problems	□ Yes □ No
Sickle cell anemia/blood disorder	□ Yes □ No
Hepatitis or liver problems	□ Yes □ No
Kidney infection	□ Yes □ No
Diabetes	□ Yes □ No
Cancer, tumor, leukemia	□ Yes □ No
Thyroid or other glandular problems	□ Yes □ No
Epilepsy, seizures, fainting	□ Yes □ No
Cerebral palsy or developmental delay	□ Yes □ No
Vision problems	□ Yes □ No
Speech or hearing problems	□ Yes □ No
Emotional or psychological problems	□ Yes □ No
Congenital birth defects	□ Yes □ No
Cleft lip or palate	□ Yes □ No
Malignant hyperthermia	□ Yes □ No
Other medical condition	□ Yes □ No
Is parent or patient pregnant?	□ Yes □ No
Latex or rubber allergy/sensitivity	□ Yes □ No

PURPOSE OF TODAY'S VISIT_____

DENTAL HISTORY

1. When and where was your child's last dental visit?_____
2. What was the purpose of that visit? _____
3. Were any x-rays taken at your child's last dental visit? □ Yes □ No
4. Did your child have difficulty cooperating? □ Yes □ No
5. Was/is your child bottle fed? □ Yes □ No
6. Was/is your child breast fed? □ Yes □ No
7. If your child has been weaned please indicate at what age:_____
8. When does your child brush his/her teeth?
   □ Upon arising □ Before going to bed
   □ Right after meals □ After eating *any* food
9. Do you assist/supervise your child's brushing? □ Yes □ No
10. Does your child take fluoride supplements? □ Yes □ No
11. Have any cavities been noted in the past? □ Yes □ No
12. Were any teeth (baby or permanent) removed by extraction? □ Yes □ No
13. Have there been any injuries to teeth, such as falls, blows, chips, etc? □ Yes □ No
14. Has anyone in the family, including parents, Had orthodontics? □ Yes □ No
15. Has your child had a toothache recently? □ Yes □ No
    If Yes, explain: _____
16. Do you expect your child to be cooperative? □ Yes □ No
17. Does your child have other siblings seen by us? □ Yes □ No

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission to be obtained from a parent or legal guardian before any dental services can be rendered. I give *my consent to* Dr Joel R Clark or Dr Trevor M Jensen, and staff to perform such treatment, services, medications, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

_____

SIGNATURE OF PARENT/GUARDIAN DATE