Children's Registration Form (please fill in completely)

Name_____Preferred name_____Date_____
Address_____City_____State_____Zip_____
Home Phone_____
Birthdate____/____/____/ Sex: M F
Father's Name_____Father's Social Security #_____
Father's Employer_____Position_____Bus. Phone_____
Mother's Name_____Mother's Social Security #_____
Mother's Employer_____Position_____Bus. Phone_____
Name of emergency contact_____Phone_____

Health Information When was your last dental appointment**?_____**

Is child under care of physician? Yes No
If so, for what_____
Is child taking medication? Yes No
If so, what_____
Has child ever been hospitalized? Yes No
If so, what_____
Has child ever had surgery? Yes No
If so, what_____
Allergy to any drugs, latex, metals? Yes No
If so, to what_____

Tonsils or adenoids been removed? Yes No
Has patient reached puberty? Yes No
If so, what age_____
Does or has child sucked thumb or fingers? Yes No
If so, until what age_____
Is patient a mouth breather while awake? Yes No
Is patient a mouth breather while asleep? Yes No
Have orthodontic appliances been worn? Yes No
Any missing teeth? Yes No
Any extra permanent teeth? Yes No
Any unhappy dental experiences? Yes No
If so, what_____

Does patient have or ever had: (please circle)

Anemia Asthma Heart Ailments
Cerebral palsy Chicken pox Convulsions
Diabetes Epilepsy Fainting Hearing Loss
Hepatitis Kidney problems Liver problems
Measles Mononucleosis Mumps
T.B. Rheumatic Fever Cold Sores

Any emotional problems? Yes No
If so, what?_____
Any speech problems? Yes No

How often does child brush teeth?
_____
Do you assist child with brushing? Yes No
Is dental floss used? Yes No
How is child's attitude towards dentistry?
_____
_____

I certify that the information above is correct. I am responsible for this account and understand that payment for all services is due upon treatment. There will be a service charge of 1.5% monthly-18% annually on accounts past due.

Signature_____Date_____

Insurance Information

Insurance Company Name & Address :_____
_____
_____

Insured Name & Addres:_____
_____

Insurance ID or SS #:_____Group #:_____

Insured Employer:_____Insured Birthdate:_____

Patient Name:_____Patient Date of Birth:_____

Relationship to insured:____self____child____spouse____other____Patient sex:____M____F

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to Dr. O'Connell of the group insurance otherwise payable to me.
Signature:_____

Is patient covered by another dental insurance plan:____Yes____No, if yes, please continue
Insurance Company Name & Address:_____
_____
_____

Insured Name & Address:_____
_____

Insured ID or SS#:_____Group#:_____

Insured Employer:_____Insured Birthdate:_____

HIPPA

We are required by law to maintain the privacy of your Protected Health Information. No information will be disclosed without written authorization, except as described in the Notice. Our office has posted the Notice of Privacy Practices for you to review. I have been informed of the above law.

Signature:_____

Record Release Form

Release records to:_____

Signature:_____Date of Release:_____