



FAMILY DENTISTRY
COLORADO SPRINGS

Child Dental Registration

Patient Information

Patient Name _____ DOB ___/___/___ Male Female
 Address _____ City _____ State ___ Zip ____
 School _____
 Patient Lives: With Both Parents With Mother With Father Other _____

Parent/Guardian Information

Parent/Guardian Name _____ DOB ___/___/___
 Phone Number: Cell _____ Home _____ Work _____
 Social Security # ____-____-____ Married Single Divorced Widowed Other
 Email Address _____
 Employer _____ Address _____
 May we use your email and/or cell phone number to send appointment reminders, confirm appointment or other information regarding your child's dental care? Yes No

Primary Dental Insurance N/A

Insurance Company _____ Group # _____ Contact # _____
 Subscriber Name (_____ Relationship to Patient _____
 DOB ___/___/___ SS/ID# _____
 Address (if different from patient) _____ City _____ State ___ Zip ____

Secondary Dental Insurance N/A

Insurance Company _____ Group # _____ Contact # _____
 Subscriber Name _____ Relationship to Patient _____
 DOB ___/___/___ SS/ID# _____
 Address (if different from patient) _____ City _____ State ___ Zip ____

How did you hear about Family Dentistry of Colorado Springs?

Referral (their name) _____ Postcard Building Sign Insurance Company
 Website Social Media Yelp Online Review Google Online Review Welcome letter/brochure
 Other _____

Emergency Contact

Name _____ Relationship to Patient _____
 Cell Phone _____ Home Phone _____

Assignment and Release (please sign this section if covered by a dental insurance policy)

I certify that I, and/or my dependent(s), have insurance coverage with _____
 (Name of Insurance Company)

and assign directly to Family Dentistry of Colorado Springs and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company and furthermore that all dental estimates provided are not a guarantee of coverage or payment and the insurance coverage policy is between myself and the dental insurance company and that Family Dentistry of Colorado Springs is the dental service provider in the relationship. I authorize the use of my signature on all insurance submissions. Family Dentistry of Colorado Springs and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services

Print Name of Parent/Guardian _____ Date ___/___/___

Signature of Parent/Guardian _____

Relationship to Patient _____



Dental and Medical History Information

Dental History

Patient Name: _____ Reason for today's visit: _____

Former Dentist: _____ City/Phone: _____/(____)_____-_____

Date of last dental exam: _____ Date of last dental x-rays: _____ How often do you brush? _____ Floss? _____

Were there treatment recommendations by your previous dentist that were not completed? Yes No

Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Mouth pain, brushing |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Foreign objects | <input type="checkbox"/> Orthodontic treatment |
| <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Burning sensation on tongue | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Chewing on one side of mouth | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> Cigarette/pipe/cigar smoking | <input type="checkbox"/> Jaw tiredness | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Lip or cheek biting | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Loose teeth/broken fillings | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Fingernail biting | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Sores/growths in mouth |

Medical History

Physician's Name: _____ City/Phone: _____/(____)_____-_____ Date of last visit: _____

Please check all that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Asthma, Use Inhaler: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Swollen Feet/Ankles |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemotherapy, when _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Therapy, when _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis, type _____ | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tumor on Head/Neck |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cough, persistent/bloody | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Disease |

Have you ever taken a medication that contains bisphosphonates? This includes brands such as Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa. Yes No

Do you wear contact lenses? Yes No

Woman only: Are you pregnant? Yes No Are you taking birth control pills? Yes No Are you nursing? Yes No

Medications (List any medications you are currently taking):

Allergies (Please check all that apply):

Aspirin Codeine Erythromycin Latex Local Anesthetic Metals Penicillin Sulfa Tetracycline Other _____

I certify to the accuracy of the above statements regarding my medical and dental history

Signature of patient, parent guardian or representative

Print name of patient, parent guardian or representative

Date