Angelica Rohner
Pediatric Dentistry
Caring For Each Child Like Our Own

Patient Registration

Health History & Dental History

PATIENT INFORMATION:

CHILD's Name: _____ Nickname:_____ DOB:_____
First Middle Last

Current Age:_____ Gender: ◯ Male ◯ Female School:_____ Grade:_____

Home Address:_____
Street City State Zip Code

What is your child's favorite: Toy_____ Activity_____ Character_____ Color_____ Person_____

With whom does the patient live? ◯ Mother ◯ Father ◯ Stepparent ◯ Grandparent ◯ Legal Guardian: _____

ACCOUNT INFORMATION: [Please check box ☐ next to legal guardian/custodial parent]

☐ GUARDIAN: _____ DOB:_____ SSN:_____
First Middle Last

Employer:_____ Email:_____ Phone:_____

Relation to Patient: ◯ Mother ◯ Father ◯ Stepparent ◯ Legal Guardian: _____

☐ GUARDIAN: _____ DOB:_____ SSN:_____
First Middle Last

Employer:_____ Email:_____ Phone:_____

Relation to Patient: ◯ Mother ◯ Father ◯ Stepparent ◯ Legal Guardian: _____

DENTAL INSURANCE INFORMATION:

Policy Holder: _____ DOB:_____ Employer:_____
First Middle Last

Insurance Company: _____ Policy ID:_____ Group #:_____

DENTAL HISTORY

Date of last dental visit:_____ Were X-rays Taken? Yes *or* No Previous Dentist:_____

What are your child's feelings about visiting the dentist? ◯ Excited ◯ Optimistic ◯ Indifferent ◯ Curious ◯ Nervous ◯ Afraid

Any past or present habits? ◯ Finger sucking ◯ Nail biting ◯ Mouth breathing ◯ Nursing ◯ Pacifier ◯ Bottle ◯ Other_____

Yes *or* No Has your child complained about any dental problems? _____

Yes *or* No Experienced any traumatic injuries to mouth, teeth, or head? _____

Yes *or* No Unusual Speech Habits? ◯ Lisp ◯ Pronunciation ◯ Delay ◯ Other:_____

Yes *or* No Lost Teeth? ◯ Natural Exfoliation ◯ Injury, brunt force trauma: Permanent or Primary

Yes *or* No If irregular tooth loss, have missing teeth been replaced?

Yes *or* No Has your child seen an orthodontist? If so, whom:_____

How many times a day does your child brush? _____ How many times is floss used? _____ Do you assist? Yes *or* No

Is fluoride taken in any form? Yes *or* No In what form? ◯ Toothpaste ◯ Mouthwash ◯ Water ◯ Supplement

HEALTH HISTORY

Child's Physician: _____ Practice:_____

Last physical examination:_____ Results:_____

Yes *or* No Does your child see a physician regularly?

Yes *or* No Adopted? From what country, International or U.S.:_____

Yes *or* No Current and up to date on all immunizations?

Yes *or* No Currently taking any medications? Medications:_____

Yes *or* No Surgery? Past or Pending Procedures:_____

Yes *or* No Ever been Hospitalized? Reason:_____

Yes *or* No Excessive bleeding when cut?

Yes *or* No Good physical coordination?

Yes *or* No Emotional conditions or disorders? Diagnosis: _____

Yes *or* No Recent head or neck injures? Elaborate:_____

Has your child had a history or difficulty with any of the following?

◯ Anemia	◯ Blood disorder	◯ Developmental delays	◯ Heart	◯ Mononucleosis	◯ Tuberculosis
◯ Acid Reflux	◯ Blood transfusion	◯ Diabetes	◯ Hepatitis	◯ MRSA infection	◯ Vision
◯ ADHD or ADD	◯ Bones	◯ Digestive problems	◯ HIV or AIDS	◯ Mumps	◯ Other _____
◯ Asthma	◯ Cancer	◯ Epilepsy	◯ Kidney	◯ Rheumatic Fever	
◯ Autism	◯ Cerebral Palsy	◯ Fainting	◯ Learning problems	◯ Seizures	
◯ Autoimmune disease	◯ Chicken Pox	◯ Frequent infections	◯ Liver	◯ Speech	
◯ Bladder	◯ Congenital defects	◯ Headaches	◯ Lung	◯ Thyroid	
◯ Bleeding	◯ Convulsions	◯ Hearing	◯ Measles	◯Toothache	

ALLERGY HISTORY

Food Allergies: _____ Environmental Allergies: _____

Medication Allergies: _____ Latex Allergy: ◯ None ◯ Adverse Reaction ◯ Diagnosed

Special Diet or Dietary Restrictions:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT: Because the patient is a minor, it is necessary for us to have consent of the parent or legal guardian prior to the rendering dental treatment. Your signature below authorizes Dr. Rohner and qualified staff members to perform dental treatment that your child may need. If the patient is in custody of a non-parent, we must have a copy of the guardianship agreement or court order before the patient is seen by Angelica Rohner Pediatric Dentistry.

AGREEMENT FOR PAYMENT: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including cost of collection, attorney fees, and court costs if such is necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama.

****I hereby acknowledge and accept Angelica Rohner Pediatric Dentistry's notice of Privacy Practices.

Signature: _____ Relationship: _____ Today's Date: _____

Who may we thank for referring you to our practice or how did you hear about us?

◯ Friend_____ ◯ Pediatrician_____ ◯ Magazine Ad_____ ◯ Google Search ◯ Facebook

HEALTH SUMMARY (FOR OFFICE USE ONLY): _____

_____ Reviewed By:_____