Drs. Perlman & Koidin, P.C.

Practice Limited to Pediatric Dentistry and Orthodontics

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PATIENT'S REGISTRATION

Patient's Name (first, middle, last) ______________________ Nickname ______________

Address ______________________

City ______________ State ______________ Zip ______________ Phone ______________

Sex ☐ Male ☐ Female Birthdate ______________ Age ______ School ______________ Grade ______

Has your child been to another dentist office or clinic? ☐ Y ☐ N Is this an emergency visit? ☐ Y ☐ N

If yes, name of former dentist? ______________ Date of last visit ______________ Purpose ______________

Have any other family members been a patient in this office before? ☐ Y ☐ N If yes, names ______________

Name of patient's legal guardian? ______________________

Father's Full Name ______________	Mother's Full Name ______________
Address ______________	Address ______________
City ______ State ______ Zip ______	City ______ State ______ Zip ______
Phone: Home ______ Work ______	Phone: Home ______ Work ______
Social Security Number ______ Birthdate ______	Social Security Number ______ Birthdate ______
Occupation ______________	Occupation ______________
Employed by ______ Bus. Phone ______	Employed by ______ Bus. Phone ______

Child lives with ☐ both parents ☐ mother ☐ father ☐ other ______________

MEDICAL INFORMATION

Child's Pediatrician ______________ Address ______________ Phone ______________

Date of last physical? ______________________

	Yes	No
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Is your child being treated for any condition presently? if so, explain ______________	☐	☐
Is your child taking any medications or drugs? if so, explain ______________	☐	☐
Has your child ever been hospitalized or had surgery? if so, explain ______________	☐	☐
Does your child have any allergies or reactions to any medications? if so, explain ______________	☐	☐

Does your child have any allergies to the following?

☐ latex ☐ epinephrine ☐ peanut ☐ penicillin ☐ other ______________

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	ADD/ADHD	☐	☐	Chronic Headaches	☐	☐	Hyperactivity
☐	☐	AIDS	☐	☐	Chronic Ear Infections	☐	☐	Kidney Disease
☐	☐	Allergies to Medication	☐	☐	Cleft Lip/Palate	☐	☐	Leukemia
☐	☐	Anemia	☐	☐	Convulsions/Seizures	☐	☐	Mental/Emotional Disturbances
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Nutritional Deficiency
☐	☐	Autism	☐	☐	Epilepsy	☐	☐	Oral Ulcers
☐	☐	Bladder Conditions	☐	☐	Eye Problem	☐	☐	Orthopedic Problems
☐	☐	Blood Transfusions	☐	☐	Excessive Bleeding Problem	☐	☐	Premature Birth
☐	☐	Birth Defects	☐	☐	Excessive Gagging	☐	☐	Rheumatic Fever
☐	☐	Bone or Joint Problems	☐	☐	Fainting or Dizziness	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Growth & Development Problems	☐	☐	Sickle Cell Anemia
☐	☐	Bruising Easily	☐	☐	Hearing/Speech Problems	☐	☐	Spina Bifida
☐	☐	Cancer or Malignancies	☐	☐	Heart Problems	☐	☐	Syndrome ______________
☐	☐	Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Child Abuse	☐	☐	Hepatitis or Liver Disease	☐	☐	Other
☐	☐	Chronic Adenoid/Tonsil Infection	☐	☐	HIV Positive			

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered.

FOR PATIENTS COVERED BY OTHER DENTAL INSURANCE

PRIMARY CARRIER

Subscriber's Name ____________________

Subscriber # ____________________

Group/Policy Number ____________________

Employer Name ____________________

Insurance Company ____________________

Insurance Mailing Address ____________________

____

Insurance Telephone Number ____________________

Subscriber's Date of Birth ____________________

I have reviewed the following treatment plan.
I authorize release of any information relating to this claim.

X ____________________

Signed parent or legal guardian

I hereby authorize payment of the dental benefits otherwise payable to me directly to Drs. Perlman & Koidin, P.C.

X ____________________

Signed insured person

SECONDARY CARRIER

Subscriber's Name ____________________

Subscriber # ____________________

Group/Policy Number ____________________

Employer Name ____________________

Insurance Company ____________________

Insurance Mailing Address ____________________

____

Insurance Telephone Number ____________________

Subscriber's Date of Birth ____________________

In order to comply with most insurance companies, we ask that you sign both X's so that we may keep your signature on file and send the claims to your insurance company.

DENTAL INFORMATION AND HISTORY

	Y	N	
Was your child bottle fed?	☐	☐	if yes, until what age ____________
Was your child breast fed?	☐	☐	if yes, until what age ____________
Has your child ever had any injuries to his teeth, mouth, head or jaws?	☐	☐	if yes, describe ____________
Does your child brush daily?	☐	☐	
Does an adult assist with the brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with the flossing?	☐	☐	

Does your child have any of the following mouth habits?

☐ finger sucking ☐ thumb sucking ☐ pacifier ☐ tongue thrusting ☐ lip sucking ☐ mouth breather ☐ teeth grinding

Does your child receive fluoride in any of the following forms:

☐ in vitamins ☐ in water supply ☐ in tablets/drops Dosage: mg/day ☐ in toothpaste ☐ in rinse/gel

Please check any of the following that may describe your child:

☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Defiant

☐ Suspicious ☐ Moody ☐ HighStrung ☐ Regular Kid ☐ Friendly ☐ Cooperative

Name of child's pet ____________ Favorite interest ____________ Favorite sport ____________

How do you expect your child to react to his visit today? ☐ excellent ☐ good ☐ fair ☐ poor ☐ don't know

How may we help to make this a positive experience for your child? ____________

Has your child had any bad past dental experiences? ☐ Yes Explain ____________

Whom may we thank for referring you to our office? ____________

FINANCIAL INFORMATION, TERMS AND CONDITIONS

As a condition of treatment by this office, all fees for private accounts must be paid at the time the service is performed unless other arrangements have been made. Payment may be by cash, check, or credit card.

For patients who carry dental insurance, this office will accept assignments of benefits. Any insurance payment not received in 90 days from date of service will be your responsibility to pay.

In consideration of the professional services rendered to my child, I agree to accept responsibility for payment of such services and I agree to pay all costs and reasonable attorney fees incurred by my failure to remit for services rendered. I grant permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree in content:

Signed X ____________________ Date ____________

Medical history reviewed and updated (front and back pages)

________	________	________	________	________
(name and date)	(name and date)	(name and date)	(name and date)	(name and date)
________	________	________	________	________
(name and date)	(name and date)	(name and date)	(name and date)	(name and date)

Please list below any new allergies or medications including the date of when this occured

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