Folan Family Dental
Registration Form for Patients 18 years of age or Younger

Patient's Name_____
Last First Middle

Address_____
Street Apt # City State Zip

Nickname_____ Birth date_____ Social Security #_____

School Name_____ Sports/hobbies_____

Parent or Guardian Name_____

If this is your first visit to our office whom should we thank for referring you?_____

If this is your first time to our office and you were not referred, how did you learn about us? _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Address_____
Street City State Zip

_____Single _____Married _____Partner _____Widowed _____Separated _____Divorced

Cell Phone_____ Home Phone_____

How would you like to receive appointment confirmation reminders? Text_____ E-mail_____ Voicemail_____

E-mail Address:_____ Social Security #_____

Employer_____ Occupation:_____ _

DENTAL INSURANCE INFORMATION

Insured's Name_____Insured ID #_____

Insurance Company_____ Group Number_____

Do you have dual coverage? Yes_____ No_____ If yes:

Insurer's Name_____ Insurer's ID #_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____ Relationship_____

Address_____

Cell Phone_____ Home Phone_____

I have read Folan Family Dental's Notice of Privacy Practices (HIPPA).
The information contained in this form is accurate to the best of my knowledge.

Parent Signature:_____ Date_____

Folan Family Dental
Medical History

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you need to pre-medicate? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? ___Yes ___No Taking oral contraceptives? ___Yes ___No Nursing? ___Yes ___No

Are you allergic to any of the following?

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics

Other If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? ___Yes ___No If yes, please explain: _____
_____
_____

Comments: _____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

April 2015