PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS)	CITY	STATE / ZIP CODE
Phone (Home / Work)		Sex M ☐ F ☐

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ☐ Yes ☐ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician_____ Phone_____

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. ☐	☐
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. ☐	☐
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. ☐	☐
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. ☐	☐
6. Has the child ever been hospitalized?	6. ☐	☐
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. ☐	☐
8. Has the child ever received a general anesthetic?	8. ☐	☐
9. Does the child have any inherited problems?	9. ☐	☐
10. Does the child have any speech difficulties?	10. ☐	☐
11. Has the child ever had a blood transfusion?	11. ☐	☐
12. Is the child physically, mentally, or emotionally impaired?	12. ☐	☐
13. Does the child experience excessive bleeding when cut?	13. ☐	☐
14. Is the child currently being treated for any illnesses?	14. ☐	☐
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. ☐	☐
16. Has the child had any problem with dental treatment in the past?	16. ☐	☐
17. Has the child ever had dental radiographs (x-rays) exposed?	17. ☐	☐
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18. ☐	☐
19. Has the child had any problems with the eruption or shedding of teeth?	19. ☐	☐
20. Has the child had any orthodontic treatment?	20. ☐	☐
21. What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22. Does the child take fluoride supplements?	22. ☐	☐
23. Is fluoride toothpaste used?	23. ☐	☐
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. ☐	☐
25. Does the child suck his/her thumb, fingers or pacifier?	25. ☐	☐
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities?	27. ☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by_____
Date_____

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Form S707

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WEST CHICAGO DENTAL CARE

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices for myself/child (ren).
I understand that duplication of records (progress notes, treatment summaries or x-rays) must be requested in writing by me. I also understand that a fee is required for this service.
I give permission for West Chicago Dental Care to release information or discuss my treatment with
__________________ ☐ Spouse ☐ Other __________

We now use Weave to confirm your dental appointment, this service sends a Text and or E-mail for you to confirm an upcoming appointment at the following intervals: 2 weeks prior, 1 week prior and 1 day prior to your appointment

May we use Weave to send you text messages to remind you of your appointment? ☐ Yes ☐ No
Smart phone number: __________________

When we confirm your dental appointment, may we send you an E-mail? ☐ Yes ☐ No
E-mail address: __________________

Can we leave a detailed message (treatment, co-pay, etc.) on your voice mail ? ☐ Yes ☐ No

Please print children names to which this would apply to:

1. __________________ 4. __________________
2. __________________ 5. __________________
3. __________________ 6. __________________

NOTE: To serve our patient's better we require a confirmation of your dental appointment. Our final notification will be by text approximately 24 hours prior to your appointment and would like verification. If you do not confirm your appointment we will considered it canceled. If you failed your appointment, a $25 fee per failed appointment will be charge to your account.

Please sign and date below:

__________________ __________
Signature of Patient (Parent if minor) Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- ☐ Individual refuse to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)