SOMA PEDIATRIC DENTISTRY

New Patient Registration

Welcome! Please take a few Minutes to fill out this form

1. Patient Information

Today's date:____________________________
Patient Name:____________________________
Date of Birth:_______________Age:_________
Circle one: [Male] or [Female]
Home Address:
____
City:_______________State:________ZIP:_____
How did you hear about us?
____
Home Phone:_____________________
Mobile Phone:____________________

2. Parent Information:

Circle One: [Mother] [Father] [Legal Guardian]

Name:____________________________________
Date of Birth:_____________________________
Social Security:_________-______-__________
Occupation:_______________________________
Home Address (if different):
____
____
Mobile Phone:_____________________________

3. Parent Information:

Circle One: [Mother] [Father] [Legal Guardian]

Name:____________________________________
Date of Birth:_____________________________
Social Security:_________-______-__________
Occupation:_______________________________
Home Address (if different):
____
____
Mobile Phone:_____________________________

Dental Insurance

Name of Insurance:___________________________
Insurance Phone #:___________________________
Primary holder's name:________________________
Primary holder's DOB:_________________________
Primary holder's S.S:________--______--_________

Do you have secondary Insurance? YES [ ] NO [ ]

Name of Insurance:____________________________
Insurance Phone #:____________________________
Primary holder's name:________________________
Primary holder's DOB:_________________________
Primary holder's S.S:________--_____--__________

*In a medical emergency where neither of the individuals can be reached, who else may we contact?

Name:____
Relationship:__________________________________
Phone:_______________________________________

Signature of parent / guardian:________________________ Relationship to patient______________Date:______

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Welcome! Please take a few Minutes to fill out this form

Patient Name:__________________________ Date of Birth:____________________Today's date:____________

1. **Is your child under a physician's care now?__________________________________ Yes[ ] No[ ]**
2. **Are all immunizations current? ____ __ Yes[ ] No[ ]**
3. **Has your child ever been hospitalized or had major operation? ________________ Yes[ ] No[ ]**
4. **Has your child ever received general anesthesia? ______________________________Yes[ ] No[ ]**
   If so, what was it for?____
5. **Is your child taking any medications at this time? _____________________________ Yes[ ] No[ ]**
6. **Is your child allergic to any food?____ Yes[ ] No[ ]**
7. **Has your child ever been to a dentist before? _________________________________ Yes[ ] No[ ]**
8. **Has your child ever been prescribed fluoride before? __________________________ Yes[ ] No[ ]**
9. **Does your child suck a thumb, finger, or pacifier?____________________________ Yes[ ] No[ ]**

***Is your child allergic to any of the following?**

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics
[ ] Other If yes, please explain: ____

10. **Has your child ever had treatment on or medical consultation for any of the following systems?**

[ ] Blood/ Circulatory
[ ] Bones
[ ] Endocrine Glands
[ ] Ears
[ ] Eyes
[ ] Gastrointestinal/ Stomach
[ ] Kidney / Bladder
[ ] Heart
[ ] Liver
[ ] Lungs
[ ] Muscles
[ ] Nervous System
[ ] Nose
[ ] Skin
[ ] Tonsils / Adenoids
[ ] My child has NOT had any treatment or medical consultation for the above systems.

11. **Has your child ever been diagnosed as having any of the following conditions?**

[ ] Anemia
[ ] Epilepsy
[ ] Arthritis
[ ] Asthma
[ ] Autism
[ ] Brain Injury
[ ] Cancer
[ ] Cerebral Palsy
[ ] Cleft Lip / Palate
[ ] Chronic Ear Infections
[ ] Convulsions / Seizures
[ ] Diabetes
[ ] Emotional Disturbance
[ ] Learning Disability
[ ] Eye Problems
[ ] Bleeding Problems
[ ] Fainting
[ ] Hearing Loss
[ ] Heart Murmur or Condition
[ ] Hemophilia
[ ] Hepatitis
[ ] HIV / AIDS
[ ] Jaundice
[ ] Leukemia
[ ] Allergy
[ ] Tetanus
[ ] Pneumonia
[ ] Premature Birth
[ ] Respiratory Syncytial Virus
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Sickle Cell Anemia / Trait
[ ] Speech Problems
[ ] Spina Bifida
[ ] Syndrome: ___________________
[ ] Other: _______________________
[ ] My child has NOT ever been diagnosed with any of the above conditions

12. **What is your reason for bringing your child to the dentist?____**

Signature of parent / guardian:_____________________ Relationship to patient_____________Date:______