Dr. Matthew Randall

CHILD / YOUTH REGISTRATION

2016

Date ______________________

Name of Patient____ SS# ______________________
First Middle Last

Date of Birth__________________________ Age ___________________Home # (___)______________

Father's Full Name__________________________SS#____________________Cell # (___)__________

Mother's Full Name__________________________SS#____________________Cell # (___)__________

Fax # (____)__________________________E-Mail Address ___________________________________

Home Address____Zip__________

Past Dental Service (check): ❑ None ❑ Emergency Only (why__________________) ❑ Regular ❑ First Visit __________

Favorite Name or Nickname______________________ Outside or Special Interest__________________

Person Responsible for Account _________________________________ Relationship______________

Social Security Number___________________________Occupation_____________________________

Employer____Work # (___)____________

Do you have Dental Insurance? Yes__________ No_________ With Whom?_____________________

Nearest Relative Not Living With You_________________________________ Relationship____________

Address__________________________________Zip_______________Phone # (___)______________

Recommended By__________________________________Patient's Physician____________________

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office. Please check yes or no to the following:

1. Is the patient presently under the care of a physician? ❑ Yes ❑ No
2. Has the patient ever had abnormal bleeding following a wound? ❑ Yes ❑ No
3. Is the patient allergic to ❑ **Penicillin** ❑ **Latex** ❑ **Sulfur** ❑ **Codeine** ❑ **Novocain** ❑ **Other**:______________________

   If so, what?____

6. Does the patient have any limiting disabilities? ❑ Yes ❑ No

   If so, what?____

7. Has the patient ever had any of the following?

a)	**Rheumatic Fever**	❑ Yes	❑ No	**h)**	**Tuberculosis**	❑ Yes	❑ No
b)	**Rheumatic Heart Disease**	❑ Yes	❑ No	**i)**	**Diabetes**	❑ Yes	❑ No
c)	**Congenital Heart Disease**	❑ Yes	❑ No	**j)**	**Liver Trouble or Jaundice**	❑ Yes	❑ No
d)	**Blood Disorder**	❑ Yes	❑ No	**k)**	**Heart Murmur**	❑ Yes	❑ No
e)	**Epilepsy or Convulsions**	❑ Yes	❑ No	**l)**	**Hepatitis**	❑ Yes	❑ No
f)	**Asthma or Hay Fever**	❑ Yes	❑ No	**m)**	**Eczema or Hives**	❑ Yes	❑ No
g)	**Mitral Valve Prolapse**	❑ Yes	❑ No	**n)**	**HIV (Aids)**	❑ Yes	❑ No

8. Has the patient been under the care of a physician for any major illness or injury other than those noted above ❑ Yes ❑ No

   If so, what? ____

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment for the child named above in my absence.

❑ I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".
❑ I would like to open a 90 day interest free account based upon my credit being approved.

I Understand That Payment Is Due At Time Of Service.
I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ OTHER

______________________________ ______________________
Signature of Parent or Guardian Date

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.

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