HOOD DENTAL CARE

Patient Registration

(Under 16 years old)

Patient Information

First Name _____ Middle Initial_____ Last Name_____ Date_____

Date of Birth _____Age_____ School _____SSN_____

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

Mother's Name _____ SSN _____ Date of Birth _____

Employer _____ Occupation _____ E-mail address _____

Father's Name _____ SSN _____ Date of Birth _____

Employer _____ Occupation _____ E-mail address _____

In the event of an emergency, whom should we contact? _____

Phone(s) _____ Relationship _____

Previous Dentist _____ Date of Last Visit _____

How did you hear about us?

__Insurance Provider List __Phonebook __Google
__www.hooddentalcare.com __Flyer __Welcome to the Neighborhood Letter
__Sign in front of office __Another Doctor __Other
__Family/Friend/Whom can we thank for referring you? _____

Insurance

Primary Dental Insurance

Subscriber _____

Relationship to patient _____

Date of Birth_____ SS# _____

Employer _____

Work Phone _____

Insurance Company _____

Ins. Phone #_____

Group # _____

Secondary Dental Insurance

Subscriber _____

Relationship to patient _____

Date of Birth_____ SS# _____

Employer _____

Work Phone _____

Insurance Company _____

Ins. Phone #_____

Group # _____

Medical History

Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time? ☐Yes ☐No

If yes, **Please list** _____

Does your child have any allergies? (red dye, penicillin, latex, sulpha, etc.) ☐Yes ☐No

If yes, please explain _____

Has the child ever been hospitalized? ☐Yes ☐No

Does the child have a history of any other illnesses? If yes, please list: _____ ☐Yes ☐No

Over →

Does the child have any inherited problems? ☐Yes ☐No

Does the child have any speech difficulties? ☐Yes ☐No

Has the child ever had a blood transfusion? ☐Yes ☐No

Is the child medically, mentally, or emotionally impaired? ☐Yes ☐No

Is the child currently being treated for any illness? ☐Yes ☐No

Has the child had any problems with dental treatment in the past? ☐Yes ☐No

Has the child ever had dental X-rays? ☐Yes ☐No

Has the child ever suffered any injuries to the mouth, head, or teeth? ☐Yes ☐No

Has the child had any problems with the eruption or shedding of teeth? ☐Yes ☐No

Has the child had any orthodontic treatment? ☐Yes ☐No

Does the child take fluoride supplements? ☐Yes ☐No

Does the child use fluoride toothpaste and/or fluoride rinse? ☐Yes ☐No

How many times are the child's teeth brushed per day? _____. When are the teeth brushed? AM / PM

Does the child suck his/her thumb, finger, or pacifier; clench or grind teeth; and/or bite fingernails, chew on pencils, ect? ☐Yes ☐No

Previous Dentist's Name _____

Address _____ Telephone _____

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

ADD/ADHD	☐Yes ☐No	Hepatitis	☐Yes ☐No
Anemia	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Arthritis	☐Yes ☐No	Immunizations	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney	☐Yes ☐No
Bladder	☐Yes ☐No	Latex Allergy	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	Liver	☐Yes ☐No
Bones/Joint	☐Yes ☐No	Measles	☐Yes ☐No
Cancer	☐Yes ☐No	Mononucleosis	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	Mumps	☐Yes ☐No
Chicken Pox	☐Yes ☐No	Pregnancy (Teens)	☐Yes ☐No
Chronic Sinusitis	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Diabetes	☐Yes ☐No	Seizures	☐Yes ☐No
Ear Aches	☐Yes ☐No	Sickle Cell	☐Yes ☐No
Epilepsy	☐Yes ☐No	Thyroid	☐Yes ☐No
Fainting	☐Yes ☐No	Tobacco/Drug Use	☐Yes ☐No
Growing Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Hearing	☐Yes ☐No	Autism	☐Yes ☐No
Heart	☐Yes ☐No	Other _____	

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

Name of Physician _____ Phone _____

Authorization

I certify that the above information is accurate to the best of my knowledge, and that I agree to be treated by Dr. Hood, his associates and the Hood Dental Care staff. I further understand that payment is due at the time of service, and should it become necessary, any attorney fees, court costs and collection fees become my responsibility and will be added to my account.

I certify that I, and/or my dependent(s), have insurance coverage as described about and assign directly to Hood Dental Care, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I have read a copy of this office's privacy practices, made available upon request.

Parent/Guardian Name (Print) _____ Date ___/___/___

Parent/ Guardian Signature_____