



NEW PATIENT REGISTRATION FORM

Parent / Guardian Name:

Today's date:

PATIENT INFORMATION					
Patient's last name:		First:		Middle:	
Birth date: / /	Age:	Height	Weight	Preferred name?	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Home phone#: ()	
City:			State:	ZIP Code:	
School Name:			City:		Grade:
We like to thank those who refer new patients! How did you hear about our office?					
Other family members seen here, and their ages:					
Name of person responsible for account:		Birth Date: / /	Relationship to child?		Home phone #: ()
Email address:		SSN:		Cell phone #: ()	
Occupation:		Employer:		Employer phone #: ()	
Address (if different from child):			How would you prefer that we contact you? (Phone, email, etc.)		

INSURANCE INFORMATION					
(Please give your insurance card to our receptionist)					
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of primary insurance:			
Primary claim submission address:					
Primary subscriber's name:		Subscriber's SSN:	Birth date: / /	Group #:	Policy #:
Patient's relationship to subscriber:		Name of secondary insurance (if applicable):			
Secondary subscriber's name:		Subscriber's SSN:	Birth date: / /	Group #:	Policy #:
Secondary claim submission address:					

Patient Name:

MEDICAL HISTORY

Pediatrician Name:		Pediatrician phone #: ()	Medical ID #/Kaiser #:
Specialist Name (if applicable):		Specialist phone #: ()	How is your child's overall health? Excellent / Good / Fair / Poor
Does your child have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list:		
Is your child taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list:		
Has your child ever had an allergic reaction to latex or a product containing latex?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:	
Has your child had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:	
Are there any behavioral or developmental problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes:	
How is your child doing in school?			
Does your child have any of the following:			
Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD / ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any disease, condition or problem not listed that you think we should know about?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If any yes, please explain:			

DENTAL HISTORY

Is this your child's first dental visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of previous dentist:		
Date of last dental exam:	Have there been any injuries to your child's teeth, jaw, or chin? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child nervous or frightened by dental visits?	Has your child had an unhappy dental experience?	
Date of last dental cleaning:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If any yes, please explain:				
What is the reason for your visit today?				
Does your child take fluoride supplements or drink fluorinated water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often does your child brush his/her teeth?	Does your child use dental floss regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child ever seen an Orthodontist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name	City	When?
Does your child have any of the following:				
Grinding/Clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing of Objects
Thumb/Finger/Lip Sucking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth-breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nail Biting
Nursing/Bottle Habits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue Thrusting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring
Pacifier Sucking Habits	<input type="checkbox"/> Yes <input type="checkbox"/> No			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Lora Foster Rode's office. I understand that I am financially responsible for any balance. I also authorize Rocklin Pediatric Dentistry to release any information necessary to process my claims.

Parent/Guardian Signature:

Date: