Child Registration

Southpointe Dental
James Lichtsinn, DDS
3210 18th Street South
Fargo, ND 58104
Phone (701) 280-1941

PATIENT INFORMATION

Childs Name _____ Sex *(circle)* **M F** Age: _____ Birthdate: _____

Primary Address: _____City:_____State:_____ Zip: _____

Phone: _____Work:_____Mobile: _____**Text conf. Yes / No** (circle one) **T-Mobile AT&T Verizon Sprint**

Whom may we thank for referring you? _____

Father's name: _____Address: *(if different from child)* _____

Phone: _____Work:_____Mobile:_____Email:_____

Mother's name: _____ Address: *(if different from child)* _____

Phone: _____Work:_____Mobile:_____Email:_____

Person to notify in case of emergency: _____

Phone: _____Work:_____Mobile:_____Email:_____

Person Responsible for Account: *(Last)* _____ *(First)* _____ *(Initial)* _____

Responsible Party Employer: _____Social Security# _____

PRIMARY INSURANCE

Policy Holder Name: _____ Relation to patient _____ DOB: _____

Employer: _____Occupation: _____

Business Address: _____Phone: _____

Insurance Company: _____ Phone: _____

Group number: _____ Insurance ID number/SSN:_____

SECONDARY INSURANCE

Policy Holder Name: _____Relation to patient _____ DOB: _____

Employer: _____Occupation: _____

Business Address: _____Phone: _____

Insurance Company: _____ Phone: _____

Group number: _____ Insurance ID number/SSN: _____

DENTAL HISTORY

What would you like us to do for your child today: _____

Former Dentist: _____ Phone: _____

Date of last dental care: _____ Date of last x-rays: _____Brushing Frequency: ____/day Floss? Yes/No

Does your child experience dental pain or discomfort? *(Circle)* Yes No

Has your child ever experienced a mouth or chin injury? (*Circle)* Yes No

Has your child have speech problems? (*Circle)* Yes No

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Has your child ever experienced an adverse reaction with a medical or dental procedure? **Yes** **No**

Child's habits affecting the mouth or teeth: **Thumb Sucking? Yes No** **Nail Biting? Yes No**

Other information about your child's dental health or previous treatment: _____

_____

Anything we can do to help make your child's visit more pleasant? _____

_____

MEDICAL HISTORY

Child's Physician/Clinic _____Phone: _____

Date of Last visit: _____ Is your child currently under physician care? Yes No

(*If yes, describe*)_____

Smoke or Use Tobacco Products? **Yes** **No**

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Select All That Apply)

❑ Aspirin Allergy ❑ Codeine Allergy ❑ Erythromycin Allergy ❑ Food Allergy

❑ Hay Fever ❑ Penicillin Allergy ❑ Sulfa Allergy ❑ Other Allergies: _____

MEDICAL CONDITIONS - (Select All That Apply)

❑ AIDS / HIV+	❑ Eating Disorder	❑ Rheumatic / Scarlet Fever
❑ Anemia	❑ Headaches	❑ Seizures
❑ Asthma	❑ Hearing Impaired	❑ Shortness of Breath
❑ Blood Disease	❑ Heart Problems	❑ Skin Rash
❑ Behavior Issues	❑ Hepatitis	❑ Spina Bifida
❑ Cancer	❑ Hemophilia / Abnormal Bleeding	❑ Thyroid Disease
❑ Chicken Pox	❑ Kidney Disease/Trouble	❑ Tonsillitis
❑ Cough, Persistent	❑ Liver Disease	❑ Tuberculosis
❑ Diabetes	❑ Psychiatric Care	❑ Other: _____
❑ Dizzy Spells/Fainting	❑ Respiratory Disease	_____

Immunizations Current? Yes No

Medications your child is taking: _____

_____

Authorization and Release I authorize and request my insurance company to pay directly to Southpointe Dental any insurance benefits otherwise payable to me. I authorize Southpointe Dental to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I authorize Southpointe Dental to use anonymous photos of my child's teeth for publications, web pages and other educational materials produced & representing Southpointe Dental without compensation to me.

Signature of parent or guardian: _____ **Date:** _____