Patient Registration and Medical History

Patient _____
First Name Middle Initial Last Name

Sex_____ Age_____ Birthday_____ Ethnicity (Race)_____

Social Security Number _____ Primary Language Spoken _____

Name of person completing this form_____

Relationship to patient_____

Pediatrician_____ Phone number_____

Does your child have any known physical disorder?_____ If so, What?_____

Is your child under the care of a physician or specialist? _____

Does your child require any pre medications before any dental procedures? _____

If so, what is the Doctor's name and telephone number? _____

Is your child on any medications? _____ List: _____

Is your child allergic to anything? _____

Is your child in good general health? _____ Please list childhood diseases _____

☐ Heart Condition	☐ Heart Murmur	☐ Cerebral Palsy
☐ Epilepsy	☐ Diabetes	☐ Sickle Cell Anemia
☐ Cleeding Disorder	☐ Hepatitis	☐ Retardation
☐ Fainting Spells	☐ Seizures	☐ Stroke
☐ Respiratory Diease	☐ AIDS/HIV	☐ Kidney Disease
☐ Bone Disease	☐ Liver Disease	☐ Asthma
☐ Allergies	☐ Tumor/Caner	☐ High/Low Blood Pressure
☐ Autism	☐ Pregnant	☐ Gum Problems
☐ Asperger	☐ Teeth Grinding	☐ ADHD
☐ Latex Allergy	☐ Brain Injury	☐ ADD

Other_____

Is this your child's first visit to a dentist? _____ Date _____

Has your child had X-Rays from another dentist? _____ Date _____

Has your child experienced an unfavorable reaction from previous dental care? _____

What particular dental problems does your child have? _____

(please fill out both sides)

Parent and/or Guardian Information

Mother or Guardian name _____ Relationship to Patient_____

Mailing address _____
Street name and number City State Zip code

Home phone number _____ Cell phone number _____

E-Mail address _____ Driver's License number _____

Date of birth _____ Social Security number _____

Place of employment _____ Work number _____

Occupation _____

Dental insurance _____

Group number _____ ID number _____

Father or Guardian name _____ Relationship to Patient_____

Mailing address _____
Street name and number City State Zip code

Home phone number _____ Cell phone number _____

E-Mail address _____ Driver's License number _____

Date of birth _____ Social Security number _____

Place of employment _____ Work number _____

Occupation _____

Dental insurance _____

Group number _____ ID number _____

Alternative Contact _____ Phone number _____

Relationship to patient _____

The above information is accurate and complete to the best of my knowledge and I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payments, and health care operations. I will not hold Tyler Dentalworks or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I also understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature _____ Date _____