



YOUTH REGISTRATION FORM

REGISTRATION INFORMATION

Patient's Full Name: _____ Today's Date: _____

How does he/she wish to be addressed: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Mailing Address: _____

E-Mail Address: _____

Home Phone #: _____ Cell/Pager #: _____

How would you like your dental appointment reminders: Phone _____ E-mail _____ Both _____

Name of School patient attends: _____

FINANCIAL RESPONSIBILITY

Person financially responsible for this account: _____

Relationship to Patient: _____

Mailing Address: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Home #: _____ E-Mail Address: _____

Work #: _____ Cell/Pager #: _____

I understand that I am financially responsible for all charges on the above mentioned patient. I also understand that payment is due on the day that services are rendered.

Signature

Date

PRIMARY/SECONDARY DENTAL INSURANCE INFORMATION (not health insurance)

Name of Individual that carries dental insurance (Policy holder): _____
Date of Birth: _____ Age: _____ Social Security Number: _____
Home Phone #: _____ Work #: _____
Employer's Name: _____
Insurance Company Name: _____
Insurance Company Mailing Address: _____
Group #: _____ Insurance Company Phone #: _____
Relationship to Patient: _____

SECONDARY DENTAL INSURANCE INFORMATION (if applicable)

Name of Individual that carries dental insurance (Policy holder): _____
Date of Birth: _____ Age: _____ Social Security Number: _____
Home Phone #: _____ Work #: _____
Employer's Name: _____
Insurance Company Name: _____
Insurance Company Mailing Address: _____
Group #: _____ Insurance Company Phone #: _____
Relationship to Patient: _____

INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT

I have reviewed the information on this form. It is accurate to the best of my knowledge. I understand that this information will be used by this office to help facilitate dental treatment. This information will be used in the strictest of confidence.

I authorize Generations Dental Care (Albert Binder, DMD and Christopher Binder, DMD, and its staff) to perform any necessary dental services that my child may need during the course of diagnosis and treatment. I understand that Generations Dental Care will try to inform a parent/guardian prior to any changes in treatment, yet I also understand that there are times when those changes are unavoidable, and I authorize the practice to make those changes.

I authorize the insurance company(s) indicated on this form to pay Generations Dental Care insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature for all insurance submissions.

I authorize Generations Dental Care to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

Responsible Party Signature

Date



GENERATIONS DENTAL CARE

YOUTH HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I prefer to be called: _____ Today's Date: _____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who should we contact? Name/Relationship: _____

Work #: _____ Cell/Pager #: _____

MEDICAL INFORMATION

Do you have a primary care physician? Yes / No If yes, Name of Physician: _____

Physician's Phone #: _____ Date of Last Visit: _____

Are you currently under the care of a Physician/Specialist? Yes / No If yes, why: _____

Physician/Specialist's Name: _____ Phone #: _____

Are you currently taking any over-the-counter, herbal, and/or prescription medications? Yes / No

If yes, please list medications: _____

For Women: Are you taking birth control pills? Yes / No Name of Birth Control: _____

Are you pregnant? Yes / No Number of Weeks into pregnancy? _____ Are you nursing? Yes / No

MEDICAL CONDITIONS

Do you, or have you had any of the following (please check yes or no):

Abnormal or Prolonged Bleeding	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcohol and/or Drug Abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes/Fever Blisters	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anxiety / Nervousness	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Immune Deficiency	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bone Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	Measles	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chicken Pox	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Colitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty Breathing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shingles	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease / Traits	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emotional Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting Spells	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Frequent Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis (TB)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Growth Disorders	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hearing Impairment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hospitalizations/Surgeries	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart Surgery/Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, for what reason & when?	_____

OTHER MEDICAL CONDITIONS

Artificial Joints/Valves Yes No Cancer/Chemotherapy Yes No
Mitral Valve Prolapse Yes No Pacemaker Yes No
Rheumatic/Scarlet Fever Yes No Heart Murmur Yes No
Have you ever taken Phen-Fen (aka Redux or Pondimin)? Yes No
Have you ever been told you need to take antibiotics prior to dental treatment? Yes No
Do you have a persistent cough (greater than 3 weeks) and/or a cough that produces blood? Yes No
Have you ever taken medications for osteoporosis or to increase bone density (i.e. Actonel, Aredia, Boniva, Forteo, Fosamax, Zometa,)? Yes No
If you answered yes to any of the above, please list the reason and date: _____

ALLERGIES

Are you allergic to any of the following:

Aspirin Yes No Codeine Yes No Local Anesthetics Yes No
Erythromycin Yes No Jewelry Yes No Latex Yes No
Metals Yes No Penicillin Yes No Seasonal/Hay Fever Yes No
Tetracycline Yes No Sulfa Yes No

Please list anything else that you are allergic to: _____

DENTAL HISTORY

When was the last time you were seen for the following:

A Dental Cleaning (Prophy): _____ An Examination by a Dentist: _____

How often do you brush your teeth? _____ How often do you floss? _____

What type of bristles does your toothbrush have? Extra Soft Soft Medium Hard

Do you visit the dentist twice a year? Yes No

Do your gums bleed? Yes No

Do you smoke or use tobacco in any form? Yes No

If yes, what type, how often and for how long? _____

Have you ever had a serious or difficult problem associated with any previous dental work? Yes No

If yes, what was the difficulty? _____

DENTAL CONDITIONS

Have you ever had or experienced any of the following:

Teeth clenching Yes No Teeth grinding Yes No
Frequent headaches Yes No Ringing in the ears Yes No
Jaw Joint discomfort, clicking or popping Yes No Mouth breathing Yes No
Tender/sore head, neck or jaw muscles Yes No Speech problems Yes No
Trouble opening your mouth widely Yes No

I affirm that this information is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff (dentists, hygienists, assistants) to perform any necessary dental services that I may need during the course of diagnosis and treatment. I understand that I am financially responsible for all charges whether or not they are paid by insurance.

Responsible Party Signature

Date

Initials: _____ Date: _____	Initials: _____ Date: _____	Initials: _____ Date: _____
Initials: _____ Date: _____	Initials: _____ Date: _____	Initials: _____ Date: _____