GENERATIONS
DENTAL CARE

# YOUTH REGISTRATION FORM

## REGISTRATION INFORMATION

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

How does he/she wish to be addressed: _____

Date of Birth: _____ Age: _____

Mailing Address: _____

E-Mail Address: _____

Home Phone #: _____ Cell/Pager #: _____

Name of School patient attends: _____

Please list any sports or instruments that the patient plays: _____

## 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

***-OVER PLEASE-***

**PRIMARY 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: _____

ID #: _____ 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: _____

ID #: _____ Group #: _____

Insurance Company Phone #: _____ Relationship to Patient: _____

**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

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# 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 ☐ No ☐ | Hemophilia | Yes ☐ No ☐ |
| Alcohol and/or Drug Abuse | Yes ☐ No ☐ | Hepatitis | Yes ☐ No ☐ |
| Anemia | Yes ☐ No ☐ | Herpes/Fever Blisters | Yes ☐ No ☐ |
| Anxiety / Nervousness | Yes ☐ No ☐ | High Blood Pressure | Yes ☐ No ☐ |
| Arthritis | Yes ☐ No ☐ | Auto Immune Deficiency | Yes ☐ No ☐ |
| Asthma | Yes ☐ No ☐ | Kidney Disease | Yes ☐ No ☐ |
| Blood Disease | Yes ☐ No ☐ | Liver Disease | Yes ☐ No ☐ |
| Blood Transfusion | Yes ☐ No ☐ | Low Blood Pressure | Yes ☐ No ☐ |
| Bone Disorders | Yes ☐ No ☐ | Measles | Yes ☐ No ☐ |
| Chicken Pox | Yes ☐ No ☐ | Psychiatric Problems | Yes ☐ No ☐ |
| Colitis | Yes ☐ No ☐ | Radiation Treatment | Yes ☐ No ☐ |
| Diabetes | Yes ☐ No ☐ | Seizures | Yes ☐ No ☐ |
| Difficulty Breathing | Yes ☐ No ☐ | Shingles | Yes ☐ No ☐ |
| Emphysema | Yes ☐ No ☐ | Sickle Cell Disease / Traits | Yes ☐ No ☐ |
| Emotional Problems | Yes ☐ No ☐ | Sinus Problems | Yes ☐ No ☐ |
| Epilepsy | Yes ☐ No ☐ | Stroke | Yes ☐ No ☐ |
| Fainting Spells | Yes ☐ No ☐ | Thyroid Problems | Yes ☐ No ☐ |
| Frequent Headaches | Yes ☐ No ☐ | Tonsillitis | Yes ☐ No ☐ |
| Glaucoma | Yes ☐ No ☐ | Tuberculosis (TB) | Yes ☐ No ☐ |
| Growth Disorders | Yes ☐ No ☐ | Ulcers | Yes ☐ No ☐ |
| Hay Fever | Yes ☐ No ☐ | Venereal Disease | Yes ☐ No ☐ |
| Hearing Impairment | Yes ☐ No ☐ | Hospitalizations/Surgeries | Yes ☐ No ☐ |
| Heart Surgery/Heart Attack | Yes ☐ No ☐ | 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: _____<br>Initials: _____ Date: _____ | Initials: _____ Date: _____<br>Initials: _____ Date: _____ | Initials: _____ Date: _____<br>Initials: _____ Date: _____ |