

Morristown Family Dentistry

Child/Youth Registration

Date _____

Patient Name _____ Preferred Name _____

SS# _____ Birthdate _____ Age _____ Sex M or F

Mother's Name _____ Father's Name _____

Preferred contact _____ cell # _____

Guardian (if not listed above) _____ cell # _____

Home Address _____ Zip _____

E- Mail Address _____ Referred By _____

Emergency contact _____ cell # _____

Does patient have dental insurance? YES _____ NO _____ With Whom? _____

What is the reason for your visit? _____

Are you presently under the care of a physician? _____ Yes No

Explain _____

Name, address and phone number of physician _____

Do you have or have you had any of the following diseases or problems?

- | | | |
|--|-----|----|
| 1. ADHD..... | Yes | No |
| 2. Arthritis..... | Yes | No |
| 3. Artificial Joints..... | Yes | No |
| 4. Asthma..... | Yes | No |
| 5. High Blood pressure..... | Yes | No |
| 6. Cardiovascular disease..... | Yes | No |
| 7. Congenital heart lesions..... | Yes | No |
| 8. Diabetes..... | Yes | No |
| 9. Fainting spells or seizures..... | Yes | No |
| 10. Hay fever..... | Yes | No |
| 11. Hepatitis, jaundice or liver disease | Yes | No |
| 12. HIV/AIDS..... | Yes | No |
| 13. Low Blood Pressure..... | Yes | No |
| 14. Psychiatric counseling..... | Yes | No |
| 15. Rheumatic fever..... | Yes | No |
| 16. Substance abuse (alcohol, drugs). | Yes | No |
| 17. Venereal disease..... | Yes | No |
| 18. Mitral Valve Prolapse..... | Yes | No |

Do you use any form of tobacco?..... Yes No

Have you ever had a serious injury to the head, face, or jaw? Yes No
If so, please list _____

Describe any heart condition _____

Are you taking any over the counter medications?..... Yes No
If so, explain _____

Have you ever had abnormal bleeding following a cut or extraction?..... Yes No

Is so, explain _____

Are you now taking:

- | | | |
|--|-----|----|
| 1. High blood pressure medication?..... | Yes | No |
| 2. Sleep medication?..... | Yes | No |
| 3. Cortisone, steroids or ACTH?..... | Yes | No |
| 4. Anticoagulants or blood thinner?..... | Yes | No |
| 5. Tranquilizers or sedatives?..... | Yes | No |

- | | | |
|---|-----|----|
| 6. Antibiotics?..... | Yes | No |
| 7. Insulin?..... | Yes | No |
| 8. Have you ever taken Fen-Phen?..... | Yes | No |
| 9. Have you ever taken a Bisphosphonate?..... | Yes | No |

List all current medications?

Females only: Are you taking birth control?.....Yes No

Are you allergic to or have you reacted adversely to?

- | | | |
|--|-----|----|
| 1. Local anesthetics?..... | Yes | No |
| 2. Penicillin?..... | Yes | No |
| 3. Other antibiotics? Specify _____ | | |
| 4. Anticoagulants or blood thinner?..... | Yes | No |
| 5. Barbiturates, sedatives or sleeping pills?..... | Yes | No |
| 6. Aspirin?..... | Yes | No |
| 7. Iodine?..... | Yes | No |
| 8. Codeine?..... | Yes | No |
| 9. Latex?..... | Yes | No |
| 10. Nickel?..... | Yes | No |
| 11. Other _____ | | |

Have you ever been under the care of a physician for any major illness or injury other than those noted above? If so, please list:

I hereby consent to all visits necessary for _____ to receive an oral evaluation, dental treatment and maintenance treatment and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the medical history is true and accurate. I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

SIGNATURE _____ Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.