Morristown Family Dentistry

Child/Youth Registration

Date:_____

Patient Name _____ Preferred Name_____
First Middle Last

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?_____

Which Pharmacy do you use?_____

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_____

_____

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.