PATIENT REGISTRATION

CHILD'S NAME_____**D.O.B**_____**SEX**____**TODAY'S DATE**_____

CELL PHONE #_____ **ALTERNATE PHONE#**_____

ADDRESS_____**CITY**_____**ZIP**_____

EMAIL ADDRESS_____

MOTHER:_____**ADDRESS:** _____

D.O.B:_____**SOCIAL SECURITY #:** _____

FATHER:_____**ADDRESS:** _____

D.O.B:_____**SOCIAL SECURITY #:**_____

EMER CONTACT NAME/#:_____**RELATIONSHIP:**_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

MEDICAL INFORMATION

___ **ADD/ADHD**
___ **Allergies** ___ **Food** ___ **Latex** ___ **Seasonal**
____ **Asthma or** ___**Reactive Airway Disease**
____ **Autism**
____ **Bleeding Problems**
____ **Blood Transfusions**
____ **Birth Defects**
____ **Cerebral palsy**
____ **Chronic Respiratory Problems**
____ **Cleft Lip or Palate**
____ **Convulsions/Seizures**
____ **Cystic Fibrosis**
____ **Developmentally Delayed**
____ **Diabetes**
____ **Depression/Anxiety**
____ **Epilepsy**
____ **GERD/ Acid Reflux**
____ **Hearing Disorder**
____ **Heart Disease**
____ **Heart Murmur** _____**Antibiotic Prophylaxis Needed**
____ **Hepatitis (Type**_____ **)**
____ **High Fever**
____ **HIV**
____ **Hospitalization**
____ **Immunodeficiency**
____ **Kidney Disease**
____ **Learning Disabled**
____ **Liver Disease**
____ **Rheumatic Fever**
____ **Scarlet Fever**
____ **Sensory integration Disorder**
____ **Speech Disorder**
____ **Surgery**
____ **Tuberculosis**
____ **Other**

Physicians name and phone number:_____
Does your child take any medications?_____
Medication(s) taken at the present time: _____
Dosage:_____
Allergy to any medications ? _____

PRIMARY DENTAL INSURANCE

Insurance Company Name:_____ **Phone Number:**_____
Insurance Company Address: _____
Group #: _____ **Member ID #:** _____
Subscribers Name as appears on card: _____
DOB:_____ **SSN:**_____
Relation:_____ **Subscriber's Employer:**_____

SECONDARY DENTAL INSURANCE

Insurance Company Name:_____ **Phone Number:**_____
Insurance Company Address: _____
Group #: _____ **Member ID #:** _____
Subscribers Name as appears on card: _____
DOB:_____ **SSN:**_____
Relation:_____ **Subscriber's Employer:**_____

CONSENT FOR TREATMENT

State law requires us to obtain your consent for contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

1. I hereby authorize and direct Dr. Peter Gurr and/or Dr. Scott Jensen, assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon my child or legal ward, dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State law requires us to mention the possible risk of numbness, infection, swelling, bleeding, and discoloration, aspiration of foreign objects, vomiting, nausea, and allergic reactions. I further understand and accept that complications may require hospitalization and may even result in death. I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that his /her judgments are advisable for my child or legal ward, with the exception of (if none state):

_____

_____

X _____ Date: _____
Signature of parent or guardian

X _____ Date: _____
Signature of parent or guardian

Notice of Privacy Practices:

I acknowledge reviewing a copy of the Notice of Privacy Practice.

X_____ Date: _____

Signature of parent or guardian

I acknowledge reviewing a copy of the appointment cancellation policy.

X_____ Date: _____

Signature of parent or guardian