Southern Maine Pediatric Dentistry

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PLEASE REVIEW ATTACHED PATIENT REGISTRATION AND MAKE ANY NECESSARY CHANGES

Patient Name: _____ **Age:**_____

Would you like to receive e-mail confirmation of your appointment?

- ❑ YES E-mail :_____
- ❑ NO

Patient Dental Insurance:

Do you currently have any of the following (check all that apply):

- ❑ NO Insurance
- ❑ Delta Dental Insurance
- ❑ Other Insurance:_____ (name)
- ❑ Mainecare/Medicaid

Signature of Responsible party: _____Date: _____

Dental and Health History Update:

Yes/No: Has your child's physician changed in the last 6 months?
Name of Physician:_____ Number: _____

Yes/No: Is your child taking any medication(s)?
Please list medication and dose: _____
_____

Yes/No: Is your child allergic to anything? Please list allergies:
_____

Yes/No: Any hospitalizations or Emergency Room visits in the last 6 months?
For what?_____

Yes/No: Have there been any changes in your child's health history?
If yes, please check all that apply.

Please check if your child has been diagnosed and/or treated for any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Hepatitis	☐ Tuberculosis	☐ Mental delays
☐ Anemia	☐ Epilepsy / Seizures	☐ Kidney Disease	☐ Congenital birth defects	☐ Physical delays
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Cerebral palsy	☐ Social delays
☐ Blood Disorder Transfusion	☐ Frequent Headaches	☐ Rheumatic fever	☐ Cleft lip / palate	☐ Speech / hearing problems
☐ Cancer / Tumors	☐ Heart Condition / Murmur	☐ Stomach / GI disease	☐ Frequent infections	☐ Other

❑ Autism, ADD, ADHD, Aspergers (please circle one)

Yes/No: Do you have any dental concerns to discuss at this visit?
_____

Signature: _____**Relationship to Patient:**_____ **Date:**_____

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