



CHILDS

Registration / History

Date _____

Patient's Name _____ D.O.B _____

Father's Name _____ Cell Phone _____

Mother's Name _____ Cell Phone _____

Street Address _____ Phone _____

City _____ State _____ Zip _____

Father Employed by _____ Phone _____

Business Address _____

Present Position _____ How long held _____

Mother Employed by _____ Phone _____

Business Address _____

Present Position _____ How long held _____

Parent's Driver's License Number _____

In case of emergency, who should be notified _____

Who will pay this account _____

Father's Social Security Number _____ Birthdate _____

Mother's Social Security Number _____ Birthdate _____

If Military, Sponsor's Social Security Number _____

Do you have insurance that may cover any part of our professional services - Yes _____ No _____

If so, name of primary company _____ Policy No. _____

Social Security No. of Policy Holder _____ Group No. _____

Do you have any other insurance _____ Yes _____ No _____

If so, name of secondary company _____ Policy No. _____

Social Security No. of Policy Holder _____ Group No. _____

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you _____

ATTENTION MILITARY: Permanent home of record, please. _____

Street Address _____

City _____ State _____ Zip _____

Date of last MEDICAL examination _____ Current Age _____

For what _____

Have you been hospitalized in last 5 years _____ if so, for what _____

Do you have or have you had:	Yes	No		Yes	No
Anemia.....	_____	_____	Asthma	_____	_____
Diabetes.....	_____	_____	Are you allergic to:		
Epilepsy.....	_____	_____	Penicillin.....	_____	_____
Hepatitis.....	_____	_____	Local Anesthetic.....	_____	_____
Rheumatic fever.....	_____	_____	Latex.....	_____	_____
Heart murmur.....	_____	_____	Medication or Drugs.....	_____	_____
Abnormal heart condition.....	_____	_____	Peanuts.....	_____	_____
Abnormal bleeding from a cut....	_____	_____	Women: Are you pregnant.....	_____	_____
HIV / AIDS.....	_____	_____			
Abnormal Blood Pressure.....	_____	_____			

If allergic to medications or drugs, indicate which ones _____

Are you taking any medication now _____ If so, for what _____

So we can serve you better, please list any disability you may have. _____

Other physical conditions of which we should be aware: _____

Name of your physician _____ Phone _____

Are you receiving care now _____ If so, nature of care _____

Are you now receiving other health care Yes No

If so, nature of care	Name of doctor	Phone

May we request your dental records Yes No

To whom should we address request _____

This information was given by _____