Patient Registration Form

Patient's Name: _____ Date of Birth: ____/____/_____ Male/ Female

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Guardian's Name: _____ Date of Birth: ____/____/_____

Guardian's Primary Phone: _____ Email: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about us? ☐ Facebook ☐ Doctor ☐ Flyer ☐ Event: _____ ☐ Other: _____

Alternate/Emergency Contact

Contact's Name: _____ Alternate Phone: _____

INSURANCE

Primary Insurance Company: _____

Subscriber name: _____ Subscriber's Date of Birth: : ___/___/_____

Employer: _____ Social Security #: _____ - _____ - _____

Subscriber # _____ Group #: _____

Secondary Insurance Company: _____

Social Security Number: _____ Group Number: _____

Group Number: _____

Insurance is a contract between you and your insurance company. We bill your insurance company as a courtesy to you but note that payment is due at time of service. Although we estimate your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You must agree to pay any portion of the charges not covered by the insurance and cost of collection.

I hereby authorize payment by my dental insurance company be directly paid to Olympic Kids Dental. I also authorize the release of any dental information necessary to process dental claims. At the discretion of the office, we may use the services of one or more credit reporting services. I acknowledge receipt of the notice of privacy practices.

Parent/Guardian Signature: _____ Date: _____

Dental History

Patient's Name_____ _ Date of Birth:__/__/____ Male ☐ Female ☐

Do you give consent to *Olympic Kids Dental* to provide Fluoride Treatment? Yes ☐ No ☐

Does the Patient have an unusual history of the following:

☐ Nursing/Bottle Habits ☐ Pacifier ☐ Thumb/Finger Sucking ☐ Dental Grinding ☐

Medical History

Name of Patient's Physician:_____ Phone:_____

Is the patient taking any medications? Yes No If Yes, Please List What?

_____

Is The Patient allergic to any of the following Substances?

Aspirin Penicillin Latex Metal/Acrylics Foods Other:_____

Please Answer ALL of The Following Questions:

AIDS/HIV ☐	Bruise Easily ☐	Developmentally Delayed ☐	Growth Issues ☐	Prosthetic Joints/ Pins ☐
Anemia ☐	Bladder Conditions ☐	Diabetes ☐	Gum Disease ☐	Psychiatric Care ☐
Asthma/Breathing Issues ☐	Bleeding/ Clotting Issues ☐	Disabilities/ Special Needs ☐	Heart Murmur/ Heart Issues ☐	Sickle Cell Anemia ☐
Autism ☐	Cancer ☐	Drug/ Alcohol Use ☐	Hepatitis/ Liver Disease ☐	Seizures/ Convulsions ☐
Arthritis ☐	Cerebral Palsy ☐	Emotional Disturbance ☐	High Blood Pressure ☐	Speech/ Hearing Issues ☐
ADHD ☐	Chemotherapy ☐	Excessive Gagging ☐	Kidney Disease ☐	
Birth Defects ☐	Child Abuse ☐	Fainting/Dizziness ☐	Leukemia ☐	Tobacco Use ☐
Bladder Condition ☐	Chronic Adenoid/ Tonsil Issues ☐	Fever Blisters ☐	Mental Health Issues ☐	Tumors/ Growths ☐
Brain Injury ☐	Cleft Lip/ Palate ☐		Orthopedic Issues ☐	Vision Issues ☐
Ears/Nose/Throat Issues ☐				

If answered "YES" To any of the above, please explain:_____

_____

Parent/Guardian:_____ Date:_____ Doctor:_____