CHILD REGISTRATION FORM **DATE** ______________________

Patient Name____
First M. Initial Last Name you like to be called

Birthdate _____/_____/_____ Age______ ☐ Male ☐ Female

Mailing Address ____ Cell Phone (________)___________________________

City, State, Zip ____ Home Phone (________)__________________________

Father's Name ____ Father's Employer ________________________________

Father's Occupation ____________________________________ Business Phone (________)________________________

Mother's Name ____ Mother's Employer ________________________________

Mother's Occupation ____________________________________ Business Phone (________)________________________

Whom may we thank for referring you? ____

In case of emergency, a local relative or friend to be notified (not living at same address).

Name ____ Relationship to Patient _____________________________

Address ____ Phone (________)________________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co. ___________________________________ Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Dependent

Mailing Address ____ Insurance Co. Phone # (________)__________________

City, State, Zip ____ Insurance Group # ________________________________

Subscriber's Name _______________________________________ Union Local # ____________________________________

Subscriber's ID# ____ Birthdate _____/_____/_____

I give my consent to Michaud Periodontics and Dental Implants to release any of my dental records to my insurance companies, physician, general dentist or any other doctor related to my care. I authorize release of any information to my medical and/or dental insurance companies relating to services with Michaud Periodontics and Dental Implants. I authorize insurance payments to be directly made to Michaud Periodontics and Dental Implants.

Both the above and the medical history on the reverse side are accurate.

____ **Date** ______/_______/_______
Signature (if patient is a minor, then parent or guardian)

Your present dentist ___________________________________ City _________________________ How long? ____________

Last dental cleaning ____

Have you ever had previous periodontal (gum treatment)? ☐Yes ☐ No

When and by whom ____

Why are you here today? ____

Name of physician __________________________________ City __________________________ Phone ________________

Check if you are allergic or have reacted adversely to any of the following?

☐ Dental anesthetics (Novacaine, etc.)
☐ Penicillin/Amoxicillin
☐ Barbiturates, sedatives, or sleeping pills
☐ Valium, Halcion, or other Benzodiazapines
☐ Codeine
☐ Percodan / Percocet
☐ Demerol
☐ Vicodin
☐ Keflex
☐ Ibuprofen
☐ Aspirin
☐ Tylenol
☐ Tetracycline
☐ Erythromycin
☐ Sulfa drugs
☐ Sulfite preservatives
☐ Latex
☐ Sutures/stitches
☐ Cipro/Clinda
☐ Iodine
☐ Other ___________________________

Have you ever used intravenous (injected) bisphosphonates (*Zometa, Aredia, or Boniva*)?______________________________

Are you now using or ever used oral (pill) bisphosphonates (*Fosamax, Actonel, or Boniva*)?_____________________________

Do you currently require an antibiotic premedication for dental appointments? ____

Are you on any special diet? ____

Do you currently smoke? Y / N Amount? ____________ Have you ever smoked? Y / N If yes, details: _______________

Smokeless tobacco / snuff? Y / N

Have you ever had extensive radiation therapy? ____

List all medications you are now taking (Rx, over the counter, or natural/herb supplements)_____________________________

____

Do you have or have you ever had any of the following diseases or problems? PLEASE CHECK IF YES:

☐ Rheumatic fever
☐ Rheumatic heart disease
☐ Pacemaker
☐ Heart murmur
☐ Heart trouble
☐ High blood pressure
☐ Artificial heart valves
☐ Artificial joints
☐ Prostate disorders
☐ Kidney disease
☐ Liver disease
☐ Hepatitis A / B / C
☐ AIDS / HIV positive
☐ Asthma
☐ Tuberculosis
☐ Respiratory (Lung) disease
☐ Arthritis
☐ Seizures or epilepsy
☐ Alcoholism
☐ Thyroid or parathyroid disorders
☐ Drug addiction
☐ Diabetes
☐ Stomach ulcers
☐ Osteoporosis/Osteopenia
☐ Glaucoma
☐ Hemophilia
☐ Bleeding disorders
☐ Sleep disorder
☐ Sleep Apnea
☐ Cancer
☐ Anemia
☐ Anxiety
☐ Depression
☐ Bi-Polar
☐ Schizophrenia

Please describe any other information you feel we should be aware of relative to your health (Surgical/Anesthesia History):

____

WOMEN:

Are you pregnant? ☐ Yes ☐ No If yes, expected delivery date _____________________

Do you think you might be pregnant? ☐ Yes ☐ No

Are you breast-feeding? ☐ Yes ☐ No

Are you taking female hormones (oral contraceptives, etc.)? ☐ Yes ☐ No

Both the above and on the reverse side are accurate.

____ **Date** _____/______/______

Signature (if patient is a minor, then parent or guardian)