Turlock Family Dentistry
3950 Geer Rd. Turlock, CA 95382
Phone: (209) 668-4013

PATIENT REGISTRATION (Child/Adolescent)

Patient Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

☐ Male ☐ Female Age: _____ Nickname: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____

Minor Living With:

☐ Both Natural Parents ☐ Natural Mother ☐ Natural Father ☐ Other _____

School Attending: _____

City: _____ State: _____

Father's Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ AGE: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____ Driver's Lic.# _____

Occupation: _____ How Long? _____

Employer: _____ Employer Phone # : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ AGE: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Social Security# _____ Driver's Lic.# _____

Occupation: _____ How Long? _____

Employer: _____ Employer Phone # : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: _____

Address: _____

Phone: _____ Relationship: _____

Dental Insurance Primary Carrier

Insurance Company: _____

Employee: _____ Date of birth: _____

Group No.: _____ Subscriber ID#: _____

Dental Insurance Secondary Carrier

Insurance Company: _____

Employee: _____ Date of birth: _____

Group No.: _____ Subscriber ID#: _____

1. Are you having pain or discomfort at this time?_____ YES NO
2. Have you been under the care of a medical doctor during the past two years?_____ YES NO

   Physician's Name_____

   Address _____Telephone_____
3. Are you now taking any medication, drugs or pills?_____YES NO

   If yes, please list:_____
4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?_____YES NO

   If yes, please list:_____
5. Indicate which of the following you have had or have at present. Please circle and provide date.

Heart Failure	YES	NO	Stroke	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Allergy to Latex	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Pain in Jaw Joints	YES	NO	Radiation Therapy	YES	NO	Phen-Fen	YES	NO
Cortisone Medicine	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO
						Drug Addiction	YES	NO

6. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?_____ YES NO
7. Do your ankles swell during the day?_____ YES NO
8. Do you use more than two pillows to sleep?_____ YES NO
9. Have you lost or gained more than 10 pounds in the past year?_____ YES NO
10. Do you ever wake up from sleep and feel short of breath? _____ YES NO
11. Are you on a special diet? _____ YES NO
12. Has your medical doctor ever said you have a cancer or tumor? _____ YES NO
13. Do you have or have you had any disease, condition, or problem not listed?_____YES NO

    If yes, please list:_____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month?_____ ☐No Are you nursing? ☐Yes ☐No Are you taking birth control pills ☐ Yes ☐ No

I understand the above infomation is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____Date_____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient)_____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (19% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____Date_____Witness_____

Parent or Responsible Party. _____Relationship to Patient___ _____