N. E. FARNEY, D.D.S.

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CHILD'S REGISTRATION FORM

REFERRED BY _____ DATE _____

NAME OF PATIENT _____
LAST FIRST MIDDLE NICKNAME

ADDRESS _____
STREET APT # CITY STATE ZIP CODE

PHONE _____ AGE _____ DATE OF BIRTH _____ SEX _____

FATHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE #

HOME ADDRESS _____
STREET APT # CITY STATE ZIP PHONE

S.S. No. _____ FATHER S.S. No. _____ MOTHER

BIRTHDATE _____ FATHER BIRTHDATE _____ MOTHER

MOTHER'S NAME _____
LAST FIRST MIDDLE WHERE EMPLOYED WORK PHONE #

HOME ADDRESS _____
STREET APT # CITY STATE ZIP PHONE

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE? ☐ YES ☐ NO

LIST THEIR NAMES _____

NAME OF FRIEND OR NEIGHBOR WHO CAN
REACH YOU IN CASE OF EMERGENCY? _____

ADDRESS _____ PHONE _____
STREET APT # CITY STATE ZIP

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD (MASTER CARD, VISA)

IS PATIENT COVERED BY
INSURANCE? IF SO _____
NAME OF INS. CO. POLICY OR ID # SUBSCRIBER NAME

_____
NAME OF INS. CO. POLICY OR ID # SUBSCRIBER NAME

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

_____ _____
Signature Of Parent Requesting Care Date

MEDICAL HISTORY

Physician_____

1. Are you having pain or discomfort at this time? . . . . . YES NO
2. Do you clinch or grind your teeth . . . . . YES NO
3. Have you been a patient in the hospital during the past two years? . . . . . YES NO
4. Have you been under the care of a medical doctor during the past two years? . . . . . YES NO
5. Are you allergic to (I.E., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? . . . . . YES NO
6. Have you ever had any excessive bleeding requiring special treatment? . . . . . YES NO
7. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies	Drug Additions
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis,
Heart Pacemaker	Cold Sores	Gonorrhea)
Heart Surgery	Epilepsy or Seizures	Genital Herpes
Artificial Joint	Arthritis	X-ray or Cobalt Treatment
Anemia	Rheumatism	Chemotherapy (Cancer, Leukemia)
Stroke	Cortisone Medicine	Fainting or Dizzy Spells
Kidney Trouble	Glaucoma	Nervousness
Ulcers	Pain in Jaw Joints	Psychiatric Treatment
Alcoholism		Sickle Cell Disease
		Bruise Easily

8. Have you ever had X-Ray Therapy? . . . . . YES NO
9. Approximate date of last dental visit?_____
10. Approximate date when teeth were last cleaned? _____
11. How often do you brush your teeth? _____
12. Do your gums bleed while brushing? . . . . . YES NO
13. Do heat, cold, or sweets cause pain in your mouth . . . . . YES NO
14. Do you have any other pain in your mouth?_____
15. Have you ever been instructed in proper care of your teeth & proper diet? . . . . . YES NO
16. Would you like to retain your healthy natural teeth as long as possible? . . . . . YES NO
17. Are you self-conscious about the appearance of your teeth? . . . . . YES NO
18. WOMEN: Are you pregnant now? . . . . . YES NO
19. List any medications you are currently taking _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Date Signature of Doctor Signature of Patient, Parent or Guardian