CHILD REGISTRATION & MEDICAL HISTORY

45005 W. Pontiac Trail, Novi, MI 48377

NoviFamilyDentist.com * Leslie Taub, D.D.S. 248-669-1040 * E-mail office@novifamilydentist.com

As required by law, our office adheres to policies to protect the privacy of information you give to us or that we maintain. This information is strictly confidential and will not be released without your written permission.

CHILD PATIENT INFORMATION:

CHILD Name_____**Date of Birth**_____

Father Name_____Date of Birth_____

Address_____Apt #_____
City_____ State_____ Zip Code_____ Marital Status_____

Phone#_____ Cell #_____ E-mail_____

Driver's License #_____ Social Security #_____

Employer_____ Phone #_____
Business Address_____City_____Zip_____
Insurance Co_____Group#_____Policy#_____

Mother Name_____ Date of Birth_____

Address_____Apt #_____

City_____State_____Zip Code_____

Phone#_____ Cell #_____E-mail_____

Driver's License #_____ Social Security #_____

Employer_____ Phone #_____
Business Address_____City_____Zip_____
Insurance Co_____Group #_____Policy #_____

IN CASE OF EMERGENCY whom should we notify (living outside the home)?
Name_____Phone#_____

Whom may we thank **for referring you?** _____
If not by referral, how did you hear about us? _____

PURPOSE OF THIS APPOINTMENT _____
Date of last dental appointment_____

Date of last medical examination_____
Are you currently under the care of a physician? Yes _____No_____
If so, what condition is being treated?_____
Name of your physician_____Phone_____
Address_____City_____

May we request your health records, if needed? Yes _____No_____

If you have dental insurance: I authorize payment of dental benefits to Leslie Taub, D.D.S. for services rendered and authorize release of any dental information necessary to process my claim. I am responsible for all costs not covered by insurance, after discounts for insurance participation.

Parent's signature _____**Date** _____

MEDICAL HISTORY:

Have you had any serious illness or operation in the last 5 years? Yes___No___

Please explain._____

Do you have, or have you had any of the following?

Previous Endocarditis	Yes___No___	Seizures/Fainting Spells	Yes___No___
Mitral Valve Prolapse	Yes___No___	Epilepsy	Yes___No___
Heart Murmur	Yes___No___	Diabetes	Yes___No___
Rheumatic Fever	Yes___No___	Hepatitis/Liver Disease	Yes___No___
Rheumatic Heart Disease	Yes___No___	Kidney Disease	Yes___No___
Any Abnormal Heart Condition	Yes___No___	Asthma	Yes___No___
Angina	Yes___No___	Sinus Trouble	Yes___No___
Prosthetic Heart Valve	Yes___No___	Breathing or Lung Disorder	Yes___No___
Joint Replacement	Yes___No___	Sexually Transmitted Disease	Yes___No___
Organ Transplant	Yes___No___	AIDS	Yes___No___
Anemia	Yes___No___	HIV Positive	Yes___No___
Blood Transfusion	Yes___No___	Tuberculosis	Yes___No___
Cancer	Yes___No___	Cold Sores or Herpes	Yes___No___
Neurologic Disorder	Yes___No___	Abnormal Blood Pressure Hi___.Lo___	No___
Hemophilia	Yes___No___	Stroke	Yes___No___

Abnormal Bleeding from a cut, previous extraction, or surgery.....Yes___No___

Do you have a history of drug or/and alcohol abuse?.....Yes___No___

Do you smoke tobacco?.....Yes____No____If so, for how long?_____

Do you chew tobacco?.....Yes____No____If so, for how long?_____

Do you use drugs or any substance for recreational purposes?.....Yes___No___

Have you had radiation treatment for a tumor, growth, or other condition of your head or neck?.....Yes___No___

Do you have any disease, condition, or problem not mentioned which we should be aware of?_____

***WOMEN*:** Are you or could you be pregnant?.....Yes____ No____

Are you nursing?.....Yes____ No____

Do you take oral contraceptives?.....Yes____ No____

MEDICATIONS & ALLERGIES:

Are you currently taking or routinely take <u>any</u> drugs or medications? Yes___ No___

If so, what?_____

_____

Are you allergic to or have you reacted adversely to:

Local anesthetics	Yes____No____	Latex	Yes___No___
Penicillin	Yes____No____	Iodine	Yes___No___
Aspirin	Yes____No____	Metals	Yes___No___
Codeine	Yes____No____	Food	Yes___No___

Any other medications_____

DENTAL HISTORY:

Have you had any serious trouble associated with previous dental treatment?

Yes____ No____ _____

Have you had previous periodontal (gum) treatment? Yes____ No____When_____

Do you have clicking or popping of your jaw when chewing or opening? Yes___ No___

Do you have difficulty opening or closing your jaw? Yes____ No____

Are your teeth sensitive to: Cold____ Heat____ Sweets____ Biting pressure____

Do you have dry mouth? Yes___No___ Do you brux or grind your teeth? Yes___No___

The information provided on this registration and medical history is accurate. I understand that I am responsible for all costs of dental treatment.

Signature of Patient_____**Date**_____

(Parent or guardian if patient is a minor)