NEW PATIENT REGISTRATION

A smile to grow with

Cheryl Kelley, D.M.D.

Diplomate, American Board of Pediatric Dentistry

DATE ______________________

Patient Name Nickname Birthdate Sex: M F

Address Phone #

City/Town Zip

Parent/Guardian Employer/Profession Bus. Phone

Parent/Guardian Employer/Profession Bus. Phone

Email Address

Brothers, Sisters (names) Child's School

Parent's Dentist Pediatrician/Group Name Phone #

How did you hear about us? Dental Insurance Co. & Contract #

Person Responsible for Account Social Security #

Who lives in the household? ______________________

Please tell us your child's interests and hobbies ______________________

MEDICAL HISTORY

1. Date of your child's last physical exam with physician ______________________

   Findings? ______________________
2. Does your child have any illness now? ______________________
3. Has your child ever been hospitalized? ( ) Yes ( ) No If yes, when and for what? ______________________
4. Is your child presently under a physician's care? ( ) Yes ( ) No If yes, for what? ______________________
5. Allergic to any medication or allergic to anything else? ______________________
6. Current medication ____________ dose ____________ for ____________

   Current medication ____________ dose ____________ for ____________
7. Circle any that your child has ever been diagnosed or treated for:

Abnormal Bleeding	ADD/ADHD	AIDS/HIV	Anemia
Anxiety	Asthma	Autism Spectrum	Bacterial/Viral Infections
Behavioral Concerns	Blood Disorder	Blood Transfusions	Cancer/Tumors
Congenital Birth Defects	Developmental Disabilities	Diabetes I/II	Eating Disorders
Eplilepsy	GERD/Reflux	Hearing Impairment	Heart Murmur
Heart Trouble	Hepatitis	Joint Problems	Kidney Disease
Learning Difficulties	Liver Disease	Seizures	Recurrent Headaches
Rheumatic Fever	Tuberculosis	Sight Problems	Speech Impediment
Physical Handicaps	Constipation	Hemophilia	Sickle Cell Anemia

Others (please list) ______________________

8. Is this your child's first visit to a dentist? ( ) Yes ( ) No Is this an emergency visit? ( ) Yes ( ) No
9. What is your reason for bringing your child in for dental care? ______
10. Has your child ever had dental x-rays? If so, when? What type? ______
11. Is there now or has there ever been any of the following? (Please circle):

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	Mouth Injuries

12. Does your child now, or in the past, have history of (please circle):

Thumb Sucking	Nighttime Bottle Usage	TMJ/TMD
Pacifier	Jaw Soreness	Teeth Grinding
Clenching Teeth	Lip Sucking	Nail Biting
Finger Sucking	Daytime Bottle Usage	

13. Has your child had an unfavorable medical or dental experience? ( ) Yes ( ) No
If yes, please explain: ______

14. Do you brush your child's teeth?	( ) Yes	( ) No
15. Does your child brush regularly?	( ) Yes	( ) No
16. Does your toothpaste contain fluoride?	( ) Yes	( ) No
17. Does your child use dental floss?	( ) Yes	( ) No
18. Is your child's water fluoridated?	( ) Yes	( ) No
19. Does your child use fluoride rinses or supplements?	( ) Yes	( ) No

20. Please add any information concerning your child's dental or medical history that you feel may be important:

______

FOR PARENT/GUARDIAN:

1. How would you rate your dental health now?	Excellent	Good	Fair	Poor
2. How would you rate your dental health as a child?	Excellent	Good	Fair	Poor

3. Do you have a fear of dental treatment? ( ) Yes ( ) No

MEDIA RELEASE

I give permission to Dr. Cheryl Kelley, A Smile to Grow With to use my name and photographic likeness and/or testimonial stated below in all form and media for education, trade, advertising, and any other lawful purpose.

Name of Patient Signature of Parent/Guardian Date

______

DENTAL CONSENT

I hereby give my consent for the dental examination of my child. This dental exam may include diagnostic x-rays, photographs and/or study models as deemed necessary for a comprehensive diagnosis.

Name of Patient Signature of Parent/Guardian Date

______

MEDICAL HISTORY UPDATE

1. Comments ______
Recorded by ______ Date ______
2. Comments ______
Recorded by ______ Date ______
3. Comments ______
Recorded by ______ Date ______
4. Comments ______
Recorded by ______ Date ______
5. Comments ______
Recorded by ______ Date ______
6. Comments ______
Recorded by ______ Date ______