Print Form

Daniel N. Galaif, D.D.S.

Patient Registration

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

PLEASE PRINT **TODAY'S DATE:** / /

CHILD'S PERSONAL INFORMATION

Child's Name *(Last, First,* Birthdate: / /

Nickname: Child's Home Phone #: ( )

Child's Street Address: Apt #:

City: State: Zip:

School: Grade:

Hobbies: Other Siblings:

Whom can we thank for referring you to us?

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: *(Last, First, M.I.):* Relationship:

Do you have legal custody of this child? ☐ Yes ☐ No

RESPONSIBLE PARTY

Who is responsible for account: Relationship to Child: ☐ Parent ☐ Guardian ☐ Other

Name *(Last, First, MI):* Birthdate: / /

Address (if different from Child's: Apt #: Phone #: ( )

City: State: Zip: Pager/Cell Phone #: ( )

Occupation: E-Mail Address:

Employer: Soc. Sec. #:

Business Street address: Business Phone #: ( )

City: State: Zip: Drivers License #:

INSURANCE INFORMATION
(Please give your insurance card to the receptionist)

Is this child covered by insurance? ☐ Yes ☐ No If yes, please complete the following:

Name of Primary Insurance:

Subscriber's name: Birthdate: / /

Soc. Sec #: Policy. #: Group #:

Relationship to Child: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian ☐ Other:

Name of secondary insurance (if applicable):

Subscriber's name: Birthdate: / /

Soc. Sec #: Policy. #: Group #:

Relationship to Child: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Other:

The above information is true to the best of my knowledge. I authorize insurance benefits to be paid directly to this office. I understand that I am financially responsible for any balance. I also authorize Daniel N. Galaif, D.D.S., or insurance company to release any information required to process claims for my child.

Signature *Relationship to Child (Patient)* *Date*

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CHILD'S DENTAL & MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your child's dental record.

Child's Name *(Last, First, M.I.):* _____ Nickname: _____

Previous Dentist: _____ Phone #: ( )

Date of last visit: / /

Physician's Name: _____ Phone #: ( )

Date of last visit: / /

CHILD'S PERSONAL HEALTH HISTORY

Have Child Ever Had The Following: ☐ Yes ☐ No If yes, please check the boxes that apply:

☐ Abnormal Bleeding/Hemophilia	☐ Heart Murmur	☐ Epilepsy	☐ Rheumatic Fever	☐ Diabetes
☐ ADD/ADHD	☐ High Blood Pressure	☐ Convulsions	☐ Scarlet Fever	☐ Lupus
☐ Aids/HIV+	☐ Low Blood Pressure	☐ Hepatitis	☐ Chicken Pox	☐ Hives
☐ Exposed to HIV, but Negative	☐ Anemia	☐ Kidney Problems	☐ Skin Rash	
☐ Congenital Heart Defect	☐ Asthma	☐ Liver Problems	☐ Measles	
☐ Mitral Valve Prolapse	☐ Cancer/Chemo	☐ Tuberculosis (TB)	☐ Hearing Impaired	
☐ Artificial Bones/Joints/Valves	☐ Ulcers/Colitis	☐ Mononucleosis	☐ Prosthetics	

Has/Does the child experience any of the following: ☐ Yes ☐ No If yes, please check the boxes that apply:

☐ Breast fed	☐ Lip Sucking/Biting	☐ Nursing Bottle Habits	☐ Tongue/Cheek Biting
☐ Chewing on Objects	☐ Mouth Breather	☐ Speech Problems	☐ Tongue Thrust
☐ Clinching/Grinding Teeth	☐ Nail Biting	☐ Thumb/Finger Sucking	☐ Use(d) Pacifier

Why did you bring the child to the dentist today? Please explain: _____

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Are the child's immunizations current? ☐ Yes ☐ No

Does the child floss his/her teeth daily? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Is the child currently under the care of a physician? ☐ Yes ☐ No

Has the child had any Hospital Stays or Operations? ☐ Yes ☐ No

Please discuss any serious medical problems the child has/had: _____

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin) ☐ Yes ☐ No

If yes, when: _____

Is the child currently taking any drugs or medicines (over the counter or prescribed)? ☐ Yes ☐ No If yes, please list:

_____ _____

_____ _____

Is the child allergic to any drugs or medicines, latex, metals/nickel or plastics? ☐ Yes ☐ No If yes, please list:

_____ _____

_____ _____

I affirm that the above information is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status

_____ _____ _____

Signature *Relationship to Patient* *Date*

Dentist's Initials: _____ *Date:* _____