TEEN REGISTRATION

Welcome to our office, we are pleased to have you here and would like to get acquainted.
To better serve you, please fill out the following information for our records. *Thank you.*

Name ______ **Date of Birth** ______ **Age** ______

Address ______ **City/Zip** ______ **Home Phone** ______

E-mail Address ______

Father's Name ______ **Father Employed By** ______ **Business Phone** ______

Mother's Name ______ **Mother Employed By** ______ **Business Phone** ______

Whom may we thank for referring you to our office ______

Name of family members who are patients ______

Person financially responsible for account (**not** an insurance company) ______

Name of primary dental insurance company ______

Subscriber Number ______ Group Number ______ Social Security Number ______

Name of secondary dental insurance company ______

Subscriber Number ______ Group Number ______ Social Security Number ______

Primary Medical Insurance ______ Subscriber Number ______ Group Number ______

Secondary Medical Insurance ______ Subscriber Number ______ Group Number ______

In case of an emergency, whom may we contact ______

Dental History

1. Is your teen having any discomfort at this time? ______
2. Are any of your teen's teeth sensitive to: Heat? ______ Cold? ______ Sweets? ______ Pressure? ______
3. How long since he/she has been to a dentist? ______ What was done then? ______
   Did he/she have X-rays? ______ If so, may we request copies? ______
   How often did he/she visit a dentist before then? ______
4. Do you think your teen has decayed teeth? ______
5. Has he/she ever had a bad dental experience? ______
6. Does he/she have any fear of having dental work done? ______ If so, what? ______
7. Does he/she have pains of the face or jaws? ______ Does he/she suffer with headaches? ______
8. Do you notice popping, clicking, or soreness of his/her jaws or in the joints just in front of the ears? ______
9. Does he/she clench or grind his/her teeth awake or sleeping? ______
10. Does your teen often press his/her tongue against the teeth? ______
11. Does your teen have difficulty swallowing? ______ Chewing food? ______
12. Does your teen have bleeding gums? ______ Does he/she have teeth that seem loose? ______
13. Has he/she ever had gum treatment? ______ If so, when? ______
14. Has he/she lost any teeth other than wisdom teeth? ______ If so, have they been replaced? ______
15. Is your teen concerned about avoiding bad breath? ______ Does he/she feel he/she has an unpleasant taste in the mouth? ______
16. How often does he/she brush his/her teeth? ______ Does he/she use any type of mouth rinse? ______
    Does he/she use dental floss? ______ How often? ______
17. Does your teen use any other fluoride other than that which is in the toothpaste? ______
18. Does he/she want to avoid dentures? ______
19. Does your teen want to know how to keep his/her remaining natural teeth? ______
20. Has your teen had his/her teeth straightened? ______ If so, when? ______
21. Would he/she like to change the appearance of his/her teeth in any way? ______
    Would he/she like his/her teeth whiter? ______ Would he/she like his/her teeth straighter? ______
23. Does he/she use any form of tobacco products? ______ If so, what and for how long? ______

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I authorize release of any information concerning dental treatment to my benefits provider and/or any pertinent dental/medical specialists. I authorize payment directly to Mid-Valley Dental of the group insurance benefits otherwise payable to me. I agree that the charges incurred through this office for dental or surgical care for myself or my family are my responsibility. Charges that are not covered by insurance payment will be paid by me.

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include radiographs, models and intraoral examination. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent to the use of local anesthetic and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them at the service, unless other arrangements are made in advance.

Signed (Patient, parent or legal guardian) ______ Date ______

TEEN MEDICAL HISTORY

Check One

YES NO 1. Has your teen been hospitalized in the last two years? If so, for what? ______________
YES NO 2. Is your teen under the care of a medical doctor?If so, for what? ______________
YES NO 3. Has he/she ever had excessive bleeding requiring special treatment? ______________
YES NO 4. Is he/she taking any prescription medications? (list below)
YES NO 5. Is your teen allergic to or made sick by any of the following? Penicillin, Aspirin, Codeine, Latex, Vaseline, Other ______
YES NO 6. Is your teen allergic to jewelry? ______________
YES NO 7. Are you allergic to any metals? If so, list known metals ______________
YES NO 8. Has your teen's physician ever prescribed antibiotics as a pre-medication prior to dental treatment? ______
YES NO 9. Has your teen's physician ever said he/she has a cancer or tumor? ______________
YES NO 10. Does your teen have any disease, condition or problem not listed below ______________

Check any of the following which you've had or are currently being treated for:

Heart Disease	Kidney Trouble	Chemotherapy	AIDS or HIV positive
High Blood Pressure	Ulcers	Cancer or Leukemia	Hepatitis A (infectious)
Heart Murmur	Cough	Arthritis	Hepatitis B (serum)
Rheumatic Fever	Tuberculosis (TB)	Rheumatism	Liver Disease
Congenital Heart Lesions	Asthma	Pain in Jaw Joints	Yellow Jaundice
Scarlet Fever	Hay Fever	Epilepsy or Seizures	Blood Transfusion
Artificial Heart Valve	Sinus Trouble	Fainting or Dizzy Spells	Drug or Alcohol Abuse
Mitral Valve Prolapse	Allergies/Hives	Nervousness	Hemophilia
Heart Surgery	Diabetes	Psychiatric Treatment	Venereal Disease
Artificial Joint	Thyroid Disease	Sickle Cell Disease	Cold Sores
Anemia	X-ray or Cobalt Therapy	Bruise Easily	Canker Sores
		Spina Bifida	Genital Herpes

Physician's Name ______________ **Phone Number** ______________

Address ______________

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, dental hygienist or dental assistant at the next appointment.

______________ ______________

Signature of Patient, Parent or Guardian **Date**

CURRENT MEDICATIONS	**REVIEW DATE**	
1.	1.	10.
2.	2.	11.
3.	3.	12.
4.	4.	13.
5.	5.	14.
6.	6.	15.
7.	7.	16.
8.	8.	17.
9.	9.	18.