MINOR PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Home Phone _____

Cell Phone _____

Patient _____
Last Name First name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Date of Birth _____

Who is responsible for this account? _____ Relationship to patient _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Name of Insurance Company _____ Group Number _____

Social Security # _____ Date of Birth _____

Second person responsible _____ Relationship to patient _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Name of Insurance Company _____ Group Number _____

Social Security # _____ Date of Birth _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Has the patient ever had any of the following? (Check boxes that apply):

- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Blood Disease
- ☐ Rheumatic Fever
- ☐ Epilepsy
- ☐ Allergies to Latex
- ☐ Frequency of Brushing _____
- ☐ Orthodontic Procedures
- ☐ Unfavorable Dental Experience
- ☐ Neurological Problems
- ☐ Psychiatric Problems
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Respiratory Disease
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Diabetes
- ☐ Oral Habits, i.e., fingernail biting, thumb sucking, mouth breathing

Does the patient have any drug allergies or ever had an adverse reaction to medication or anesthetics? ☐ Yes ☐ No

If so, what _____

Taking any medication at this time? ☐ Yes ☐ No If so, what _____

Under the care of a physician? ☐ Yes ☐ No For what conditions? _____

Is there anything else we should know about the patient's medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold Dr. Watson or his staff responsible for errors or omissions that I may have made in the completion of this form.

Date _____ Signature (parent/guardian) _____