Today's Date _____
D M Y

YOUTH PATIENT REGISTRATION **WELCOME TO OUR OFFICE** **ALL INFORMATION IS CONFIDENTIAL**

The following information is required by our office to assist in proper diagnosis and treatment. Our staff are always available to help you complete this form. Thank you for choosing our office and we look forward to working together with you.

PATIENT'S NAME: _____ PREFERS TO BE CALLED: _____
(surname) (first) (initial)

PATIENT'S HOME ADDRESS: _____
(apt. #) (street) (town/city) (province) postal code)

PATIENT'S TELEPHONE NUMBERS: (____) _____ (____) _____
(home) (work)

SCHOOL: _____ GRADE: _____

DATE OF BIRTH _____ Sex _____

MOTHER'S NAME: _____ TELEPHONE NUMBERS: (____) _____ (____) _____
(applicable) (home) (business)

HOME ADDRESS: _____
(street) (city) (province) (postal code)

BUSINESS ADDRESS: _____
(employer) (street) (city) (province) (postal code)

FATHER'S NAME: _____ TELEPHONE NUMBERS: (____) _____ (____) _____
(applicable) (home) (business)

HOME ADDRESS: _____
(street) (city) (province) (postal code)

BUSINESS ADDRESS: _____
(employer) (street) (city) (province) (postal code)

FAMILY DENTIST: _____ PHONE: (____) _____

FAMILY PHYSICIAN: _____ PHONE: (____) _____

PERSON RESPONSIBLE FOR ACCOUNT: Self / If other: Name: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ RELATIONSHIP: _____ PHONE: (____) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IS ANOTHER FAMILY MEMBER A PATIENT AT OUR OFFICE? _____

MEDICAL HISTORY

Have you ever had a serious illness requiring hospitalization or extensive medical care?_____YES NO

Specify:

Are you presently being treated by a physician?_____YES NO

If so, explain _____

Have you had a medical examination in the last year?_____YES NO

Do you use any prescription or non-prescription medicine regularly?_____YES NO

Do you have any allergies? Penicillin / ASA / Sulfa / Nickel / Latex / Other: _____YES NO

Do you have or have you ever had any of the following? (please circle)_____

heart murmur or other heart condition	diabetes
rheumatic or scarlet fever	radiation treatment or chemotherapy
hepatitis A/B/C	ear, nose or throat ailment
seizures	respiratory problems, e.g. asthma
HIV/AIDS	tonsils/adenoids removed
prosthetic joint replacement	head or facial trauma
bleeding abnormalities	bone disorder

DENTAL HISTORY

1. How frequently do you see your dentist? _____
2. When was your last dental appointment? _____
3. What type of dental treatment have you had in the past? _____
4. Have you ever had any jaw joint (TMJ) problems? _____

_____

Patient Authorization