



CHILD REGISTRATION FORM

DATE _____

Patient Name _____
be called First M. Initial Last Name you like to

Birthdate ____/____/____ Age _____ Male Female

Mailing Address _____ Cell Phone (_____) _____

City, State, Zip _____ Home Phone (_____) _____

Father's Name _____ Father's Employer _____

Father's Occupation _____ Business Phone (_____) _____

Mother's Name _____ Mother's Employer _____

Mother's Occupation _____ Business Phone (_____) _____

Whom may we thank for referring you? _____

In case of emergency, a local relative or friend to be notified (not living at same address).

Name _____ Relationship to Patient _____

Address _____ Phone (_____) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Patient's Relationship to Subscriber:

Self Spouse Dependent

Mailing Address _____ Insurance Co. Phone # (_____) _____

City, State, Zip _____ Insurance Group # _____

Subscriber's Name _____ Union Local # _____

Subscriber's ID# _____ Birthdate ____/____/____

I give my consent to Michaud Periodontics and Dental Implants to release any of my dental records to my insurance companies, physician, general dentist or any other doctor related to my care. I authorize release of any information to my medical and/or dental insurance companies relating to services with Michaud Periodontics and Dental Implants. I authorize insurance payments to be directly made to Michaud Periodontics and Dental Implants.

Both the above and the medical history on the reverse side are accurate.

Signature (if patient is a minor, then parent or guardian)

Date ____/____/____

Your present dentist _____ City _____ How long? _____

Last tooth cleaning _____

Have you ever had previous periodontal (gum treatment)? Yes No

When and by whom _____

Why are you here today? _____

Name of physician _____ City _____ Phone _____

Check if you are allergic or have reacted adversely to any of the following?

Dental anesthetics (Novacaine, etc.)	Penicillin/Amoxicilin	Barbiturates, sedatives, or sleeping pills
Valium, Halcion, or other Benzodiazapenes	Codeine	Percodan / Percocet
Demerol	Vicodin	Keflex
Ibuprofen	Aspirin	Tylenol
Tetracycline	Erythromycin	Sulfa drugs
Sulfite preservatives	Latex	Sutures/stitches
Ciproflox/Klynda	Iodine	Other _____

Have you ever used intravenous (injected) bisphosphonates (*Zometa, Aredia, or Boniva*)? _____

Are you now using or ever used oral (pill) bisphosphonates (*Fosamax, Actonel, or Boniva*)? _____

Do you currently require an antibiotic premedication for dental appointments? _____

Are you on any special diet? _____

Do you currently smoke? Y / N Amount? _____ Have you ever smoked? Y / N If yes, details: _____

Smokeless tobacco / snuff? Y / N

Have you ever had extensive radiation therapy? _____

List all medications you are now taking (Rx, over the counter, or natural/herb supplements) _____

Do you have or have you ever had any of the following diseases or problems? PLEASE CHECK IF YES:

Rheumatic fever	Rheumatic heart disease	Pacemaker	Heart murmur
Heart trouble	High blood pressure	Artificial heart valves	Artificial joints
Prostate disorders	Kidney disease	Liver disease	Hepatitis A / B / C
AIDS / HIV positive disease	Asthma	Tuberculosis	Respiratory (Lung)
Arthritis disorders	Seizures or epilepsy	Alcoholism	Thyroid or parathyroid
Drug addiction	Diabetes	Stomach ulcers	
Osteoporosis/Osteopenia		Bleeding disorders	Sleep disorder
Glaucoma	Hemophilia	Anemia	Anxiety
Sleep Apnea	Cancer	Schizophrenia	
Depression	Bi-Polar		

Please describe any other information you feel we should be aware of relative to your health: _____

WOMEN:

Are you pregnant? Yes No If yes, expected delivery date _____

Do you think you might be pregnant? Yes No

Are you breast-feeding? Yes No

Are you taking female hormones (oral contraceptives, etc.)? Yes No

Both the above and on the reverse side are accurate.

Date ____/____/____

Signature (if patient is a minor, then parent or guardian)