Apple Seeds Pediatric Dentistry
Dental Health for the little ones in our Family

FAMILY DENTAL HEALTH
Family & Cosmetic Dentistry for All Ages

CAROLINA FAMILY
ORTHODONTICS

Patient Registration Form

(Please Print)

PATIENT NAME _____ TODAY'S DATE_____

DOB_____ SSN#_____ MARITAL STATUS (PLEASE CIRCLE ONE) M S D

ADDRESS_____

CITY, STATE, ZIP_____

TELEPHONE #'S: HOME_____ WORK_____ CELL_____

EMAIL:_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cell:_____

Reponsible party (if patient is under 21)_____

Responsible Party EMAIL:_____

Have you been to any practice within our FDH family; including: Apple Seeds Pediatric Dentistry and Carolina Family Orthodontics?

YES/NO If so, where?_____

Please list any immediate family members that have been to any practice within our FDH family including Apple Seeds Pediatric Dentistry and Carolina Family Orthodontics?_____

How did you hear about Family Dental Health?_____

PRIMARY INSURANCE

POLICYHOLDER'S NAME

_____

SS#_____ ID#_____

DOB_____ MARITAL STATUS M S D

EMPLOYER_____

INSURANCE CO_____

INS CO TELEPHONE #_____

GROUP #_____

SECONDARY INSURANCE

POLICYHOLDER'S NAME

_____

SS#_____ ID#_____

DOB_____ MARITAL STATUS M S D

EMPLOYER_____

INSURANCE CO_____

INS CO TELEPHONE #_____

GROUP #_____

- I authorize the release of any information/diagnosis and the records of any treatment examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.
- Payment is due when services are rendered. Balances over 90 days are subject to a monthly finance charge of 1.5%. Failure to make your account current may result in collection of the account by an independent third party whose fees will be the responsibility of the below signing patient or responsible party.
- I, the undersigned do fully understand that my insurance will be filed as a courtesy and that I am fully responsible for any treatment costs which are denied or not covered by my insurance. I further agree that it is my responsibility to know my benefits, restrictions, and limitations.

Patient Signature (Parent if Minor)

_____ Date_____

Printed Name of Patient (Parent if Minor)_____

Health History for Family Dental Health

Patient Name:_____ **DOB:**_____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand the question):

1 Is your general health good?_____ **YES NO**
2 Has there been a change in your health within the last year? **YES NO**
3 Have you been hospitalized or had a serious illness in the last three years? **YES NO**
If YES, why? _____
4 Are you under the care of a physician? **YES NO** Name:_____ Phone:_____
5 Have you had problems with prior dental treatment?_____

II. ARE YOU/HAVE YOU/DO YOU:

6 Taking Blood Thinners? (Coumadin, Plavix, aspirin, etx.) _____ **YES NO**
7 Allergic to penicillin or other antibiotics?_____ **YES NO**
8 Allergic to latex? **YES NO**
9 Have a pacemaker? Placed: _____ **YES NO**
10 Use tobacco products? Please specify:_____ **YES NO**
_____
11 Experienced any bleeding problems? (hemophilia, clotting deficiencies, etc.) **YES NO**
12 Taking bisphosphonates (Fosamax, Boniva, Aredia, Zometa, Reclast, Actonel, etx.)? **YES NO**
13 Sensitive to dental anesthetics? **YES NO**
14 Drink alcohol? How much/How often?_____ **YES NO**
15 Use recreations drugs? What type?_____ **YES NO**

III. HAVE YOU/DO YOU:

16 Possess a medical condition that requires antibiotics prior to dental treatment? **YES NO**
17 Had any total joint replacements? If yes, date(s) placed:_____ **YES NO**
18 Had any organ transplants or been told you are immune compromised? If yes, date(s)_____ **YES NO**
19 Have a damaged heart valve? **YES NO**
20 Had a prosthetic heart valve or repair with a prosthetic material? If yes, date(s)_____ **YES NO**
21 Been told you have a congenital heart abnormality? **YES NO**
22 Rheumatic fever? **YES NO**

IV. HAVE YOU EXPERIENCED:

23 Chest pain (angina)? **YES NO**
24 Shortness of breath? **YES NO**
25 Bleeding problems, bruising easily? **YES NO**
26 Persistent cough, coughing up blood? **YES NO**
27 Difficulty swallowing? **YES NO**
28 Frequent vomiting, nausea? **YES NO**
29 Dizziness or fainting spells? **YES NO**
30 Ringing in ears? **YES NO**
31 Chronic headaches? (# per week)_____ **YES NO**
32 Dry mouth? **YES NO**

V. DO YOU HAVE/HAVE YOU HAD:

33 Heart disease? **YES NO**
34 Heart attack(s)? Year(s)_____ **YES NO**
35 High blood pressure? **YES NO**
36 Stroke, hardening of arteries? **YES NO**
37 Asthma, TB, Emphysema, other lung diseases? **YES NO**
38 Hepatitis, other liver disease? **YES NO**
39 Diabetes? **YES NO**
40 HIV/AIDS? **YES NO**
41 Cancer, chemotherapy, radiation? **YES NO**
42 Arthritis, rheumatism? **YES NO**
43 Skin disease? **YES NO**
44 VD (syphilis or gonorrhea)? **YES NO**
45 Herpes? **YES NO**
46 Kidney, bladder disease? **YES NO**
47 High Cholesterol? **YES NO**

VI. WOMEN ONLY:

48 Is there any chance that you may be pregnant? **YES NO**
49 Are you nursing? **YES NO**

VII. ALL PATIENTS:

50 Please list any drugs that you are allergic to:_____

51 Please list any other allergies that you have (metals, cats/dogs, etc.):_____

52 Please list any over-the-counter medications or herbal supplements that you take regularly:_____
_____

53 Please list any medicines that you are currently prescribed, including birth control pills:_____
_____

54 Do you have or have you had any other diseases or medical problems NOT listed on this form? Yes NO If so please explain:_____
_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change to my health and or medication.

Patient's Signature (Parent if minor)_____ **Date:**_____