RED ROSE DENTISTRY

Dr. Emily Eckdahl Dr. Terence Geary

Child Registration

Today's Date _____
Patient's Name _____
Child's preferred nickname _____
Address_____
City _____
State _____ Zip _____
Home Phone Number (_____) ____-_____
Patient's Age _____
Patients Date of Birth _____
Patient's School _____
Purpose of Todays Visit _____
_____

Mother's Name _____
Mothers Occupation _____
Employer _____
Work Phone (____) ____-_____
How Long Held? _____
May We Confirm Appointments At Your Place Of Business? ___Y ___N

Father's Name _____
Father's Occupation _____
Employer _____
Work Phone (____) ____-_____
How Long Held? _____
May We Confirm Appointments At Your Place Of Business? ___Y ___N

Primary Dental Insurance Information

Policyholder's Name _____
Policyholder's Date of Birth _____
Insurance Company _____
Insurance Company Telephone (___)____-_____
Employer _____
SSN _____-_____-_____
Member # _____ Group #_____

Secondary Dental Insurance Information

Policyholder's Name _____
Policyholder's Date of Birth _____
Insurance Company _____
Insurance Company Telephone (___)____-_____
Employer _____
SSN _____-_____-_____
Member # _____ Group #_____

Dental History

	Yes	No
Is this your child's first dental visit?	____	____
If not, when was the last visit? _____		
What was done? _____		
Name of Office _____		
Does your child eat a well balanced diet?	____	____
Does your child eat between meals?	____	____
What types of Snacks? _____		
Do you have fluoridated water in your home?	____	____
Who brushes the child's teeth? _____		
When? _____		
Is the child bothered by the thought of going to the Dentist?	____	____
Does the child have any thumb or finger sucking habits?	____	____
Explain _____		

_____Please complete back page _____

Medical History

	YES	NO
Does your child have any Health Problems?	____	____
If yes, Explain _____		
Is your child under a Physician's care now?	____	____
For What? _____		
Physician's Name _____		
Address _____		
Phone Number _____		
Is your child currently taking any medications?	____	____
Please List _____		
Does your child have any allergies?	____	____
Please List _____		
Does your child need to take a premedication prior to dental treatment?	____	____

Check any of the following that your child has had or has currently:
____ Diabetes
____Asthma
____Heart Trouble
____Rheumatic Fever
____Hemophilia
____Epilepsy
____Hepatitis
____Abnormal Bleeding
____A.I.D.S.
____Artificial Joints
____Physical or Emotional Problems
____Other _____

CONSENT:
The undersigned hereby authorizes Red Rose Dentistry and staff to take x rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Geary to make a thorough diagnosis of the patient's dental needs. I also authorize Red Rose Dentistry to perform any and all treatment that may be needed.

Parent _____ Date _____
(signature)
Dentist _____
(signature)

I give permission for Red Rose Dentistry and its doctors to use my child's photographs/x rays for education and marketing purposes over all their platforms ___N ___Y

Parent _____ Date _____
(signature)