BURKE DENTAL, PLLC

CHILD REGISTRATION FORM

LAST NAME	FIRST NAME	MI	DOB	GENDER: M /F
NAME OF PARENTS	PARENT'S E-MAIL ADDRESS			
ADDRESS				
CITY	STATE	ZIP	HOME PHONE	
MOM'S CELL	DAD'S CELL	REFERRED TO OFFICE BY		
MOM'S EMPLOYER		MOM'S WORK PHONE		
DAD'S EMPLOYER		DAD'S WORK PHONE		
PHYSICIAN	PHONE	CITY/STATE		
EMERGENCY CONTACT	EMERGENCY PHONE	PHARMACY PHONE		

MEDICAL HISTORY

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
☐	☐	ABNORMAL BLEEDING	☐	☐	GLAUCOMA	☐	☐	STROKE
☐	☐	ALCOHOL ABUSE	☐	☐	HIV+ AIDS	☐	☐	THYROID PROBLEMS
☐	☐	ALLERGIES	☐	☐	HAY FEVER	☐	☐	TUBERCULOSIS
☐	☐	ANEMIA	☐	☐	HEART ATTACK	☐	☐	ULCERS
☐	☐	ANGINA PECTORIS	☐	☐	HEART MURMUR	☐	☐	YELLOW JAUNDICE
☐	☐	ARTHRITIS	☐	☐	HEART SURGERY			**ALLERGIES**
☐	☐	ARTIFICIAL BONES	☐	☐	HEMOPHILIA	☐	☐	ASPIRIN
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HEPATITIS A	☐	☐	CODEINE
☐	☐	ASTHMA	☐	☐	HEPATITIS B	☐	☐	DENTAL ANESTHETICS
☐	☐	BLOOD TRANSFUSION	☐	☐	HEPATITIS C	☐	☐	ERYTHROMYCIN
☐	☐	CANCER-CHEMOTHERAPY	☐	☐	HIGH BLOOD PRESSURE	☐	☐	JEWELRY
☐	☐	COLITIS	☐	☐	HPV	☐	☐	LATEX
☐	☐	CONGENITAL HEART DEFECT	☐	☐	KIDNEY PROBLEMS	☐	☐	METALS
☐	☐	COSMETIC SURGERY	☐	☐	LIVER DISEASE	☐	☐	PENICILLIN
☐	☐	DIABETES	☐	☐	LOW BLOOD PRESSURE	☐	☐	TETRACYCLINE
☐	☐	DIFFICULTY BREATHING	☐	☐	MITRAL VALVE PROLAPSE	OTHER ALLERGIES		
☐	☐	DRUG ABUSE	☐	☐	PREMED			
☐	☐	EMPHYSEMA	☐	☐	PACE MAKER	**Y**	**N**	
☐	☐	EPILEPSY	☐	☐	PAIN IN JAW JOINTS	☐	☐	SMOKE OR CHEW TABACCO?
☐	☐	FAINTING SPELLS	☐	☐	PSYCHIATRIC PROBLEMS			**FEMALES ONLY:**
☐	☐	FEVER BLISTERS	☐	☐	RHEUMATIC FEVER	☐	☐	PREGNANT OR NURSING
☐	☐	FREQUENT HEADACHES	☐	☐	SEIZURES	☐	☐	TAKING BIRTH CONTROL PILLS
			☐	☐	SINUS PROBLEMS			

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

HAS ANYONE EVER TOLD YOU THAT YOU SNORE? Y / N

IS THERE ANY DISEASE, CONDITION, OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD KNOW ABOUT THAT IS NOT COVERED ABOVE?

HAVE YOU EVER TAKEN ANY BISPHOSPHONATES MEDICATIONS (such as Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa, or Reclast)? Y / N

HAVE YOU EVER HAD ANY BAD EXPERIENCES AT THE DENTAL OFFICE?

IS THERE ANYTHING THAT YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

OFFICE POLICIES AND CONSENT FOR TREATMENT

BEFORE TREATMENT CAN BE RENDERED, ADEQUATE RADIOGRAPHS OF THE TEETH AND MOUTH MUST BE TAKEN.

WE USE LOCAL ANESTHETIC AND OTHER METHODS OF PAIN CONTROL TO MAKE OUR PATIENTS MORE COMFORTABLE WHILE RECEIVING DENTAL TREATMENT.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF DENTAL OR ORAL SURGICAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, WAS GIVEN A COPY OF BURKE DENTAL, PLLC NOTICE OF PRIVACY PRACTICES.

INSURANCE INFORMATION

Sponsor's Name	Sponsor's DOB	Sponsor's SSN

PRINT YOUR NAME

SIGNATURE OF PARENT	DATE

For Office Use Only: Entered by_____Checked by_____Scanned By_____