PERRY L. JEFFRIES, DDS and ASSOCIATES, PA
Dr. P.L. Jeffries and Associates, PA
DENTISTRY for KIDS

Patient Registration

First Last MM DD YY

Patient's Name _____ Sex: Male/Female Date of Birth_____

Social Security #_____School_____Grade_____

Street Address_____

City _____State_____ Zip Code_____

First Last MM DD YY

Mother/Guardian's Full Name_____ Date of Birth _____

Social Security#_____ Driver License#_____

Home Phone#_____ Cell Phone # _____

Employer _____Work Phone#_____

First Last MM DD YY

Father/Guardian's Full Name_____ Date of Birth _____

Social Security#_____ Driver License#_____

Home Phone#_____ Cell Phone # _____

Employer _____Work Phone#_____

E-Mail Address _____Marital Status of Parents: Married/Separated/Divorced/Other

Name of nearest relative not living with you _____Phone#_____

Whom may we thank for referring you to us _____

Do you have dental insurance: Y/N Medicaid: Y/N Do you have more than one dental insurance: Y/N

Payment of Professional Fees: The policy of payment for dental services in this office will be cash, check, Visa or MasterCard. Payment is expected the day that services are rendered. Portions of the bill not covered by dental insurance or Medicaid are the responsibility of the parent/legal guardian and are due in full at the time of each dental visit. The parent must provide proper identification and the dental insurance and/or Medicaid card on the day of the visit.

I understand and agree to these terms. Signature _____ Date_____

ASSIGNMENT AND RELEASE:

I, the under signed certify that I and/or my dependent(s), have insurance coverage with _____ and I hereby authorize my insurance benefits to be paid directly to Perry L Jeffries, DDS and Associates, PA / PL Jeffries, DDS and Associates, PA and I am financially responsible for non-covered services and charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information. I also authorize Perry L Jeffries, DDS and Associates, PA / PL Jeffries, DDS and Associates, PA to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Print Parent Name/Legal Guardian _____ Relationship to Patient: _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Medical History

	Y	N	?	Explain		Y	N	?	Explain
Hearing Problems					**Problems at birth**				
Eye Problems					**Heart Murmur**				
Skin Problems					**Rheumatic Fever**				
Tonsil/Adenoid Problems					**Anemia**				
Emotional/Behavioral Problems					**Sickle Cell Anemia**				
Attention Deficit Disorder					**Bleeding/Hemophilia**				
Hepatitis					**Blood Transfusion**				
AIDS or HIV					**Arthritis**				
Tuberculosis					**Cancer**				
Liver Disease					**Cerebral Palsy**				
Kidney Disease					**Seizures**				
Diabetes					**Autism**				
Asthma					**Cleft Lip**				
Speech Problems									

If yes to any above, please explain

_____

_____

Is your child taking any medication at this time? (please list) _____

Name of Patient's Primary Physician _____ **Last Exam Date** _____

Allergies (please list) _____

Dental History

What is your main concern about your child's dental health (problem)?

_____

_____

Has your child been to a dentist before? Y/N If Yes, Date of last visit:_____

Date of last X-Ray:_____**Former Dentist Name:**_____

Reason for leaving former dentist: _____

Yes	No	?	
			Has your child experienced an unusual reaction to dental medication or anesthetic?
			Has your child experienced prolonged bleeding following dental treatment?
			Will your child be uncooperative?
			Has your child experienced any complications following dental treatment?
			Has your child inherited any family facial or dental characteristics?
			Has your child had any injury to teeth, jaws, or face?
			Has your child had any clicking or pain in the jaw joints?
			Was your child breastfed? What age stopped?
			Was your child bottle-fed? What age stopped?
			Did your child use a pacifier? When stopped?
			Did your child suck a finger or thumb? When stopped?
			Do your child's gums bleed when brushed?
			Did you or your child ever get instructions in brushing?
			Does your child use fluoride products: rinses, drops, tabs?
			Does your child use dental floss?

Please check if your child has had problems with any of the following:

_____ Cavities _____Color of Teeth _____ Teeth Sensitive to Hot or Cold _____ Bleeding Gums_____ Tooth Aches
_____ Gum Infection ____Teeth Sensitive to Sweets ___ Look of Teeth _____Tooth Bumped _____Grinds Teeth
____ Other Dental Problems (list) _____

Explanations and comments:

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist, and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment. I consent to treatment and authorize dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

PERSON COMPLETING THIS FORM

Signature: _____ Date: _____

Relationship to Patient: _____

Medical and Dental History Reviewed By: _____ Date: _____