

JONATHAN A. LEVEY, D.D.S.
FAMILY DENTISTRY
PATIENT REGISTRATION FORM

Child's Name _____ Nickname _____

Sex: ___ Male ___ Female Age ___ Birthdate _____

Soc. Sec. # _____

School _____ Grade _____

Child's Home Address _____

City _____ State _____ Zip _____

Home Phone _____

In case of an Emergency, call _____ Phone# _____

Mother ___ stepmother ___ guardian ___

Father ___ stepfather ___ guardian ___

Name _____

Name _____

Address _____

Address _____

City _____ St _____ Zip _____

City _____ St _____ Zip _____

Home Phone _____

Home Phone _____

Work Phone _____

Work Phone _____

Employer _____

Employer _____

Occupation _____

Occupation _____

Soc.Sec.# _____

Soc.Sec.# _____

Primary Dental Insurance

Insured's Name _____

Relationship _____ Birthdate _____ Soc.Sec.# _____

Employer _____ Date of Hire _____

Employer's Address _____ City _____ St _____

Insurance Company _____ Group # _____

Address of Insurance Company _____

Phone # of Insurance Company _____

Secondary Dental Insurance

Insured's Name _____

Relationship _____ Birthdate _____ Soc.Sec.# _____

Employer _____ Date of Hire _____

Employer's Address _____ City _____ St _____

Insurance Company _____ Group # _____

Address of Insurance Company _____

Phone # of Insurance Company _____

Whom may we thank for referring you? _____

I have reviewed the treatment plan and authorize the release of informaton related to this Dental claim and authorize payment of all the Dental Benefits directly to the attending dentist.

Signature of parent or guardian _____ Date _____

JONATHAN A. LEVEY, D.D.S.

MEDICAL HISTORY

Child's Name: _____

Your child's overall health as well as any medications which your child takes could have in important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Child's Physician _____ Phone # _____
Date of last physical exam _____ Is child under the care of a physician now? Yes/No
If yes, please explain _____
Please list all medications currently being taken, including vitamins _____

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS? Yes/No
IF YES, PLEASE LIST _____

HEALTH HISTORY

Has your child ever had any of the following:

Asthma	Yes/No	Handicaps/Disabilities	Yes/No
Cancer	Yes/No	Tuberculosis	Yes/No
Hepatitis	Yes/No	Diabetes	Yes/No
HIV/AIDS	Yes/No	Rheumatic Fever	Yes/No
Hemophilia	Yes/No	Congenital Heart Defect	Yes/No
Abnormal Bleeding	Yes/No	Heart Murmur	Yes/No
Allergies	Yes/No	Convulsions/Epilepsy	Yes/No

Please explain any medical problems that your child has _____

DENTAL HISTORY

How often does your child brush? _____ How often does your child floss? _____

Has your child had difficulty with previous dental visits? _____

Does your child:

Suck thumb/Finger	Yes/No	Child's first visit?	Yes/No
Suck/Bite lips	Yes/No	If No, date of last dental visit	_____
Bite/Chew nails	Yes/No	Previous Dentist	_____
Chew hard objects		Phone #	_____
(pencils, etc.)	Yes/No	Is your child's water fluoridated?	Yes/No
Grind Teeth	Yes/No	Does your child take	
Clench Jaws	Yes/No	fluoride supplements?	Yes/No

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND CURRENT AND THAT I WILL NOTIFY THIS OFFICE OF ANY CHANGES.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____
SIGNATURE OF DENTIST _____ DATE _____