Renee Commarato, DDS, MS

Pediatric Dentistry 8845 East Market Street, Warren, Ohio

CHILD'S REGISTRATION AND HISTORY

Child's Name: ______________________________ Preferred Name ____________
first middle last

Age ______ Date of Birth ____/____/____ Sex ______ Social Security #: ______-______-______ Ht ______ Wt ______

Home Address ______________________________ City ____________ State ______ Zip ______

Telephone # (____) ____________ Reason for Visit ______________________________

Child lives with ❑ both parents ❑ mother ❑ father ❑ shared custody ❑ other ____________

Child's Interests, Favorite sports, Name of pet: ______________________________

Names and Ages of Siblings ______________________________

Whom may we thank for referring you to our office ____________________ If not referred, how did you hear of our office ______________________________

Mother's Name: ______________________________ Date of Birth ____/____/____ Social Security # ______-______-______
first middle last

Address ______________________________ City ____________ State ______ Zip ______

Home Phone # (____) ____________ Business Phone # (____) ____________ Cell Phone # (____) ____________

Email Address: ______________________________ Marital Status : ❑single ❑divorced ❑married ❑widowed

Employer ______________________________ Occupation ____________

Business Address ______________________________ City ____________ State ______ Zip ______

Father's Name: ______________________________ Date of Birth ____/____/____ Social Security # ______-______-______
first middle last

Address ______________________________ City ____________ State ______ Zip ______

Home Phone # (____) ____________ Business Phone # (____) ____________ Cell Phone # (____) ____________

Email Address: ______________________________ Marital Status : ❑single ❑divorced ❑married ❑widowed

Employer ______________________________ Occupation ____________

Business Address ______________________________ City ____________ State ______ Zip ______

Legal guardian, if other than parent ____________________ Relationship ____________

Date of Birth ______________________________ Social Security # ______-______-______

Address ______________________________ Phone # (____) ____________

FOR PATIENTS COVERED BY DENTAL INSURANCE

Primary Carrier

Subscriber Name ____________________

Group Id Number ____________________

Policy Number ____________________

Employer Name ____________________

Insurance Company Name ____________________

Phone Number ____________________

Address ____________________

How long has this coverage been in effect? ____________

Secondary Carrier

Subscriber Name ____________________

Group Id Number ____________________

Policy Number ____________________

Employer Name ____________________

Insurance Company Name ____________________

Phone Number ____________________

Address ____________________

How long has this coverage been in effect? ____________

MEDICAL INFORMATION

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no.

Y	N	Condition
❑	❑	AIDS/HIV
❑	❑	Allergies Environmental/Symptoms ________________ Medication/Symptoms___________________
❑	❑	Anemia
❑	❑	Asthma
❑	❑	Autism
❑	❑	Birth Defects
❑	❑	Bladder Conditions
❑	❑	Blood Transfusion Date: ____________
❑	❑	Bone or Joint Problems/Arthritis
❑	❑	Brain Injury/Damage
❑	❑	Bruises Easily
❑	❑	Cancer or Tumor
❑	❑	Cerebral Palsy
❑	❑	Child Abuse
❑	❑	Chronic Ear Infections
❑	❑	Chronic Headaches
❑	❑	Chronic Tonsillitis
❑	❑	Cleft Lip/Palate
❑	❑	Convulsions/Seizures
❑	❑	Cystic Fibrosis
❑	❑	Developmental Delays ❑ Mental ❑ Physical
❑	❑	Diabetes
❑	❑	Emotional Disturbances
❑	❑	Epilepsy
❑	❑	Eye/Vision Problem
❑	❑	Excessive Gagging
❑	❑	Fainting or Dizziness
❑	❑	Growth and Development Problems
❑	❑	Head/Face Injury
❑	❑	Hearing/Speech Problems
❑	❑	Heart Murmur
❑	❑	Heart Disease
❑	❑	Hemophilia
❑	❑	Hepatitis/Liver Disease Type: ________
❑	❑	Hyperactivity/ADD/ADHD
❑	❑	Kidney Disease
❑	❑	Learning Disabilities
❑	❑	Leukemia
❑	❑	Mental Retardation
❑	❑	Nutritional Deficiency
❑	❑	Oral Ulcers
❑	❑	Orthopedic Problems
❑	❑	Premature Birth
❑	❑	Rheumatic Fever
❑	❑	Scoliosis
❑	❑	Sickle Cell Anemia
❑	❑	Spina Bifida
❑	❑	Syndrome______________
❑	❑	Tuberculosis
❑	❑	Other ________________

May we request a release of your child's medical records if deemed necessary for our records? ❑ Yes ❑ No

Please describe any current medical treatment (including medication, pending surgery, recent injury or any other information) I should be aware of that has not been mentioned above: ____

____

Child's Pediatrician ______________________ Phone #: (   ) ____________ Address ___________________________

Date of Last Physical ___/____/____ Results ____

Specialist MD ___________________ Specialty _____________ Phone #: (   ) ___________ Date Last Seen _________

Specialist MD ___________________ Specialty _____________ Phone #: (   ) ___________ Date Last Seen _________

Question	Y	N
Is your child in good health?	❑	❑
Are your child's immunizations up to date?	❑	❑
Is your child being treated presently for any condition? If yes, explain ________________________________	❑	❑
Is your child taking any medication or drugs? (Include non-prescription medications)	❑	❑
If yes, what ____________________ dosage _______		
If yes, what ____________________ dosage _______		
Was your child born prematurely? If Yes how many weeks?_________________	❑	❑
Did your child have any problems at birth? If yes, explain ________________________________	❑	❑
Has your child ever been hospitalized or had surgery? If yes, date________ explain ___________________	❑	❑
Was general anesthesia used?	❑	❑
Does your child have any allergies or reaction to medications? If yes, explain symptoms_____________________ ____ (Include non-prescription medications)	❑	❑
Does your child swallow tablets?	❑	❑
Chew tablets?	❑	❑
Take liquids?	❑	❑

DENTAL INFORMATION

Is this your child's first dental visit? ❑ Yes ❑ No Previous Dentist ______________ Date of last cleaning and fluoride _______

Date of last visit__________ Reason for last visit_________________ Were X-Rays taken? ❑ Yes ❑ No ❑ Uncertain

Present dental problem, if any, as you see it ____

Have there been any injuries to your child's teeth, mouth or jaws ❑ Yes ❑ No

If yes, when and which teeth were treated: ____

	Y	N	
Was your child bottle fed?	❑	❑	If yes, age discontinued ______________________
Was your child breast fed?	❑	❑	If yes, age discontinued ______________________
Does your child brush daily?	❑	❑	How frequently? ❑ AM ❑ PM ❑ After Meals ❑ After snacks ❑ Bedtime
Does your child floss daily?	❑	❑	How frequently? ❑ Daily ❑ Weekly ❑ When food gets caught
Do you help your child brush?	❑	❑	How frequently? ❑ Each time ❑ Once a day ❑ Occasionally
Do you help your child floss?	❑	❑	How frequently? ❑ Daily ❑ Occasionally

Does your child have (or previously had) any of the following habits? ❑ Finger sucking ❑ Thumb sucking ❑ Tongue Thrusting
❑ Lip sucking ❑ Mouth breather ❑ Tooth grinding ❑ Pacifier Age when discontinued? ________________

Does your child receive Fluoride in any of the following forms? ❑ swish at school ❑ in vitamins ❑ in water supply
❑ in tablets/drops Dosage:_______ mg/day ❑ in toothpaste ❑ in rinse/gel ❑ unsure

Please check the following to describe your child's temperament: ❑ outgoing ❑ shy ❑ stubborn ❑ anxious
❑ frightened ❑ defiant ❑ suspicious ❑ moody ❑ high strung ❑ easy going ❑ friendly ❑ cooperative

Has your child had a difficult previous dental experience? ❑ Yes ❑ No Explain:___________________________

____

List any questions you would like answered____

____

AUTHORIZATION AND FINANCES – TERMS AND CONDITIONS

The person bringing the patient to this office is responsible for fees incurred. As a condition of treatment by this office, all fees must be paid at the time the service is performed. Payment may be made by cash, check or credit card. For the patients who carry dental insurance, similar terms apply. We will gladly file your claim for you as a courtesy. You are responsible for any deductible and copayment at the time of service. If the dental insurance carrier pays less than the actual bill for service, the balance is the responsibility of the subscriber. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

How do you intend to pay? Check one ❑ Cash ❑ Check ❑ Visa ❑ MasterCard ❑ Discover

The information I have provided is correct to the best of my knowledge. I understand that any information not given that adversely affects treatment is my responsibility. I understand it is my responsibility to inform Dr. Commarato and her staff of any changes in my child's medical status.

I authorize and request my insurance company to pay Dr. Commarato all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize Dr. Commarato to release any information including diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners.

I give my permission to Dr. Commarato and her staff to use measures deemed necessary in their professional judgment to provide routine treatment to my child. Routine treatment may include, but not be limited to cleanings, fluoride, topical and local anesthetics, intermittent radiographs, silver fillings, white fillings, sealants, nerve treatments, stainless steel crowns, extractions, space maintainers and nitrous oxide analgesia. I understand a treatment plan will be reviewed with me prior to treatment.

In consideration for the professional service rendered to my child, I agree to accept responsibility for the payment of such services, I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters concerning the treatment of my child.

I have read the above conditions of treatment and agree and give my consent.

Parent/Guardian ______________________________ Date __________________

Name of Child ____

In the event of an emergency, or if we are unable to reach you, whom can we contact?

Name: ____Relationship: ______________________________________

Phone #( ) - ________________________________Alternate #( ) - ________________________________

Witness ____