

Fort Worth Children's Dentistry
JACK W. MORROW, D.D.S, M.S.D.
DREW JAMISON, D.D.S.
 Patient's Registration and History

Date _____

Child's Name _____ Age _____ Date of Birth _____

Prefers to be called _____ Sex _____ Weight _____

What other children in your family have we seen? _____

Who referred your child to our office? _____

Pediatrician (physician) _____

I. CHILD'S MEDICAL HISTORY:

Yes No

- | | | |
|--|--------------------------|--------------------------|
| 1. Does your child have any known physical disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your child have any allergies (penicillin, asthma, etc.)?
What? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your child receiving any medications now?
What? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Has your child had any history of or difficulty with any of the following?:

- | | | | | |
|--------------------------|-------------------------------------|--------------------------|-------------------------|--------------------|
| _____ Anemia/Sickle Cell | _____ Convulsions | _____ Hepatitis | _____ Pregnancy | _____ Transfusions |
| _____ Asthma | _____ Diabetes | _____ Kidney Disorders | _____ Rheumatic Fever | _____ AIDS |
| _____ Autism | _____ Epilepsy | _____ Liver Disease | _____ Sinus Problems | _____ HIV Positive |
| _____ Bladder Disease | _____ Emotional/Behavioral Disorder | _____ Lung Disease | _____ Thyroid Disorders | _____ Other |
| _____ Blood Disorders | _____ Fainting | _____ Malignancies | _____ Tuberculosis | _____ _____ |
| _____ Bleeding Disorders | _____ Hearing/Speech Disorder | _____ Mental Retardation | _____ Vision Disorders | _____ _____ |
| _____ Cerebral Palsy | _____ Heart Disorders | | | |

II. CHILD'S DENTAL HISTORY:

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Has child had any unfavorable dental experiences? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has child had any injuries to the mouth or teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does child have a toothache now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does child have any mouth habits? (thumbsucking, pacifier, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Last dental examination/x-rays _____ | | |

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child. _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

OVER

III. GENERAL INFORMATION

Parent or Guardian responsible for this account:

Father _____ Full Name Mother _____ Full Name

Birth Date: _____ Birth Date: _____

SS#: _____ SS#: _____

Cell #: _____ Cell #: _____

Email: _____ Email: _____

Married Separated Divorced Single

Address _____

City _____ State _____ Zip _____ Home Telephone _____

In case of emergency whom may we contact (Name, relationship, phone). _____

List other names to whom we may release information: _____

Place of employment and occupation:

Father: _____ Work Phone _____

Mother: _____ Work Phone _____

Dental Insurance Information:

Policy Holder's Name: _____ DOB _____ SS# _____ Relationship _____

Dental Insurance Company's Name: _____ Employer _____

Group #: _____ Phone _____

All fees for services rendered are payable at the conclusion of each appointment unless other financial arrangements have been made. I agree to be responsible for payment of all services rendered for this child. If applicable I authorize my Insurance Company to pay directly to Dr. Morrow and/or Dr. Jamison. I understand that my dental insurance carrier may pay less than the actual bill for services and that I am responsible for the balance.

V. CARE OF PATIENTS

At the first visit the teeth are cleaned then x-rayed for children over 3 years of age. If the child is suffering from a toothache, emergency treatment will be provided. No fillings or extractions will be done on the child's first visit. An account of the services to be rendered and cost of the complete case will be given to the parent before any treatment is begun.

In providing dental care, we will treat your child as we would our own. Numbing agents and dental gas are used routinely to help overcome the fear of dental care. Dentistry is an important health service for your child, and we will attempt to provide your child a satisfying experience in our office.

VI. CONSENT FOR TREATMENT OF A MINOR:

The undersigned hereby authorizes Dr. Morrow and/or Dr. Jamison to perform the examination including x-rays, and after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in force and effect until cancelled by either party.

Signed _____

Date _____ Relationship _____