

929 South Main Street • P.O. Box 458 Blackstone Va 23824

## **Children's Registration Form**

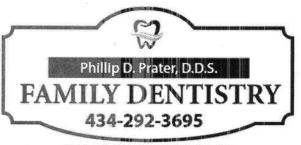
Patient's name:	The supplementary of the suppl	Date of Birth:	ä	
Sex: Name of le	egal guardian:			
Home phone:	Mobile p	ohone:		
Email address:	The state of the s			
Mailing address:			Zip	
Whom may we thank for referring	you to our office?			
Insurance Information:	** x			
o Not covered by dental ins	urance			
Member ID#:	Dental Insurance (	Company:		
Group Number:	Claims Address:			
Covered by secondary insura	nce? Yes or No (circle one)	à		
Subscriber's Name:		**		
Subscriber's dental insurance con	npany:	Group number:		
Subscriber's birthday:	SS# or Membe	er ID#:		

\*Please complete the medical health history on the back of this form\*

## **Health Information**

## **Date of Last Dental Visit:**

1. Yes No ADD/ADHD 2. Yes No Altergies (if yes please specify) 3. Yes No Anxiety/Panic 4. Yes No Asthma 5. Yes No Autistic 6. Yes No Blood Disease 7. Yes No Cancer 21. Yes No Mental Disorders 9. Yes No Dizziness 23. Yes No Mental Disorders 10. Yes No Down Syndrome 24. Yes No Respiratory Problems 11. Yes No Excessive Bleeding 25. Yes No Stomach Problems 12. Yes No Fainting 27. Yes No Stroke 14. Yes No Grinting 27. Yes No Stroke 15. Yes No Hay Fever 29. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tuberculosis 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Kidney Disease  Name of Child's Physician  Office Number  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  Medical History Reviewed Signature/Date:  Medical History Reviewed  Signature/Date:  Medical History Reviewed  Signature/Date:  Medical History Reviewed  Signature/Date:  Medical History Reviewed  Signature/Date:	Have y	you ever l	nad ai	ny of the following?				
3. Yes No Asthma 5. Yes No Asthma 5. Yes No Blood Disease 7. Yes No Cancer 21. Yes No Mental Disorders 8. Yes No Diaztiness 22. Yes No Mental Disorders 9. Yes No Dizziness 23. Yes No No Revious Disorders 10. Yes No Down Syndrome 24. Yes No Radiation Treatment 11. Yes No Epilepsy 25. Yes No Respiratory Problems 12. Yes No Excessive Bleeding 26. Yes No Stornach Problems 13. Yes No Fainting 27. Yes No Storke 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tuberculosis 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Kidney Disease  Name of Child's Physician Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Medical History Reviewed		1. Yes	No	ADD/ADHD				
4. Yes No Asthma 5. Yes No Autistic 6. Yes No Blood Disease 7. Yes No Cancer 21. Yes No Liver Disease 8. Yes No Diabetes 22. Yes No Mental Disorders 9. Yes No Dizziness 23. Yes No Nervous Disorders 10. Yes No Down Syndrome 24. Yes No Radiation Treatment 11. Yes No Epilepsy 25. Yes No Respiratory Problems 12. Yes No Excessive Bleeding 26. Yes No Stomach Problems 13. Yes No Fainting 27. Yes No Stomach Problems 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Heart Murmur 30. Yes No Unders 17. Yes No Heart Murmur 30. Yes No Unders 18. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Kidney Disease  Name of Child's Physician Office Number  Does the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:    Date:		2. Yes	No	Allergies (if yes please specify)				
5. Yes No Blood Disease 7. Yes No Blood Disease 7. Yes No Cancer 21. Yes No Liver Disease 8. Yes No Diabetes 22. Yes No Mental Disorders 9. Yes No Diabetes 22. Yes No Mental Disorders 10. Yes No Down Syndrome 24. Yes No Nervous Disorders 11. Yes No Excessive Bleeding 25. Yes No Respiratory Problems 12. Yes No Excessive Bleeding 26. Yes No Stomach Problems 13. Yes No Fainting 27. Yes No Storoke 14. Yes No Growths 28. Yes No Tumors 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Hepatitis 31. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Does the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  To Be Completed By Office Staff:  Medical History Reviewed		3. Yes	No	Anxiety/Panic				
6. Yes No Cancer 21. Yes No Liver Disease 7. Yes No Cancer 22. Yes No Mental Disorders 8. Yes No Diabetes 22. Yes No Mental Disorders 9. Yes No Dizziness 23. Yes No Nervous Disorders 10. Yes No Down Syndrome 24. Yes No Radiation Treatment 11. Yes No Epilepsy 25. Yes No Radiation Treatment 11. Yes No Epilepsy 25. Yes No Stomach Problems 12. Yes No Excessive Bleeding 27. Yes No Stroke 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Ulcers 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hopatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Stroke 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Does the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  To Be Completed By Office Staff:  Medical History Reviewed		4. Yes	No	Asthma	194			
7. Yes No Cancer 21. Yes No Liver Disease 8. Yes No Diabetes 22. Yes No Mental Disorders 9. Yes No Dizziness 23. Yes No Nervous Disorders 10. Yes No Down Syndrome 24. Yes No Radiation Treatment 11. Yes No Epilepsy 25. Yes No Respiratory Problems 12. Yes No Excessive Bleeding 26. Yes No Stomach Problems 13. Yes No Fainting 27. Yes No Storocke 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Does the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  To Be Completed By Office Staff:  Medical History Reviewed		5. Yes	No	Autistic				
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9. Yes No Dizziness 23. Yes No Nervous Disorders 10. Yes No Down Syndrome 24. Yes No Radiation Treatment 11. Yes No Epilepsy 25. Yes No Respiratory Problems 12. Yes No Excessive Bleeding 26. Yes No Stomach Problems 13. Yes No Fainting 27. Yes No Stomach Problems 13. Yes No Fainting 27. Yes No Stomach Problems 13. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number Office Nu		7. Yes	No	Cancer	21.	Yes	No	Liver Disease
10. Yes No Down Syndrome 11. Yes No Epilepsy 25. Yes No Respiratory Problems 12. Yes No Excessive Bleeding 26. Yes No Stroke 13. Yes No Fainting 27. Yes No Stroke 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No High Blood Pressure 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  Medical History Reviewed  13. Yes No Tuberculosis 28. Yes No Tuberculosis 30. Yes No Tumors 30. Yes No Ulcers 31. Yes No Developmentally Delayed 31. Yes No Developmentally Delayed 32. Yes No Developmentally Delayed 33. Yes No Developmentally Delayed 34. Yes No Developmentally Delayed 35. Yes No Developmentally Delayed 36. Yes No Developmentally Delayed 37. Yes No Developmentally Delayed 38. Yes No Tumors 39. Yes No Tumors 30. Yes No Tumors 40. Yes		8. Yes	No	Diabetes	22.	Yes	No	Mental Disorders
11. Yes No Epilepsy 12. Yes No Excessive Bleeding 13. Yes No Fainting 13. Yes No Fainting 14. Yes No Growths 15. Yes No Hay Fever 16. Yes No Heart Murmur 17. Yes No Heart Murmur 18. Yes No Heart Murmur 19. Yes No Hopatitis 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician  Does the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  Medical History Reviewed  To Be Completed By Office Staff:  Medical History Reviewed		9. Yes	No	Dizziness	23.	Yes	No	Nervous Disorders
12. Yes No Excessive Bleeding 26. Yes No Stomach Problems 13. Yes No Fainting 27. Yes No Stroke 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  Medical History Reviewed		10. Yes	No	Down Syndrome	24.	Yes	No	Radiation Treatment
13. Yes No Fainting 27. Yes No Stroke 14. Yes No Growths 28. Yes No Tuberculosis 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No High Blood Pressure 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  To Be Completed By Office Staff:  Medical History Reviewed		11. Yes	No	Epilepsy	25.	Yes	No	Respiratory Problems
14. Yes No Growths 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No Jaundice 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  To Be Completed By Office Staff:  Medical History Reviewed		12. Yes	No	Excessive Bleeding	26.	Yes	No	Stomach Problems
14. Yes No Growths 15. Yes No Hay Fever 29. Yes No Tumors 16. Yes No Heart Murmur 30. Yes No Ulcers 17. Yes No Hepatitis 31. Yes No Developmentally Delayed 18. Yes No Jaundice 19. Yes No Jaundice 20. Yes No Kidney Disease  Name of Child's Physician Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  To Be Completed By Office Staff: Medical History Reviewed		13. Yes	No	Fainting	27.	Yes	No	Stroke
16. Yes No Heart Murmur  17. Yes No Hepatitis  17. Yes No Hepatitis  18. Yes No Developmentally Delayed  18. Yes No Jaundice  19. Yes No Jaundice  20. Yes No Kidney Disease  Name of Child's Physician  Office Number  Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain.  Does the patient live in an area where water supply is fluoridated? Yes No  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):  PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:  To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.  Parent/Guardian Signature:  Date:  Medical History Reviewed					28.	Yes	No	Tuberculosis
16. Yes No Heart Murmur  17. Yes No Hepatitis  18. Yes No Developmentally Delayed  19. Yes No Developm		15. Yes				Yes	No	Tumors
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Date: To Be Completed By Office Staff:  Medical History Reviewed	change	es regardir	g the	patient's health or medications.		accurate	ely. I	will inform my dentist of any
Medical History Reviewed						12		
	To Be	Completed	Ву О	ffice Staff:				
Signature/Date:				Medical Histo	ry Reviewed			
	Sign	nature/Da	ite:					



929 South Main Street • P.O. Box 458 Blackstone Va 23824

## **Acknowledgement of Notice of Privacy Practices**

\*You May Refuse to Sign this Acknowledgement\*

I acknowledge that I have been informed of Prater Family Dentistry's privacy practices. I am aware that a copy of this office's notice of privacy practices is available for my review.

My or my minor child's dental history and account can be discussed with the following person(s), until revoked by me in writing.

(Name)		(Relation)		(Phone)
ķ.	IC.,			
	*	*		
Printed Name		Signature		Date
				*
The second secon	For	Office Use Only	i V	

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)