ADEL M. TAWADROS, D.D.S., M.P.H.

Pediatric Dentistry

PATIENT REGISTRATION

DATE _____

Reason For Today's Visit _____

Patient's Name: _____ Preferred Name: _____ Sex: _____

Street Address: _____ Birthdate: _____ Age: _____

City, State, Zip: _____

Home Phone: _____ E-mail Address: _____

With Whom Does the Patient Live: _____ Relationship: _____

In Case of Emergency, Please Contact: (Other Than Parents): _____

Phone Number: _____ Relationship: _____

MEDICAL HISTORY

Does the patient have, or ever had, diseases or deformities of the:

Heart? _____

Liver? _____

Kidney? _____

Respiratory System? _____

Other? _____

Has the patient ever had a seizure? _____

If so, when was the last episode? _____

Does the patient tend to bleed excessively? _____

If so, when was the last episode? _____

Has the patient ever been hospitalized overnight? _____

If so, when and why? _____

What allergies or sensitivities, if any, does the patient have? _____

What medications, if any, is the patient taking now? _____

Are patient's immunizations up to date? _____

Does the patient have any problems not listed above? _____

Name of Pediatrician: _____

DENTAL HISTORY

Parental concerns: _____

When was patient's last dental visit? _____

Name of dentist: _____

Has the patient experienced any complications concerning previous dental visits? _____

If so, please explain: _____

Does the patient require antibiotic premedication prior to dental visits? _____

Please briefly state the family's (parents and siblings) experience concerning:

- dental caries (cavities): _____
- periodontal disease: _____
- tenpromandibular joint (TMT) disorders: _____
- orthodontic history: _____
- dental surgeries: _____

RESPONSIBLE PARTY

Mother's Name: _____

Address: (if different than patient's) _____

City & State: _____

Social Security # _____ Birthdate: _____

Employer: _____

Occupation: _____

Work Phone: _____ Ext. _____

Father's Name: _____

Address: (if different than patient's) _____

City & State: _____

Social Security # _____ Birthdate: _____

Employer: _____

Occupation: _____

Work Phone: _____ Ext. _____

PARENTS ARE RESPONSIBLE FOR ALL FEES REGARDLESS OF DENTAL INSURANCE COVERAGE

If you have dental insurance and would like our office to help file forms on your behalf, please complete this section.

Insurance Company Name: _____

Insured Member: _____

Policy # _____ Group #: _____ Phone: # _____

☐ The Patient Is Covered Under More Than One Policy

Carrier: _____ Member: _____ SS#: _____

OTHER FAMILY MEMBERS (Children)

Name	Birthdate	Relationship

How Were You Referred To Our Office? _____