Norman Cognetto, D.D.S.
Patrick Micaroni, D.D.S.

Patient's Registration and History Form

Patient's Name: ______________________________ Nick Name: ______________________

____ Male ____ Female Birth Date: ____/____/____

Address: ______________________________ City: ________________ State: ______ Zip: ________

School: ______________________________________ Grade: ________

Patient lives with: ___ Both Parents ___ Mother ___ Father Other: ____________________

Father's Name: __________________________ Birth Date: ___/___/___ Soc. Security No.: _____-_____-_____

Home/Cell: ______________________ Father's Employer: ______________________________

Mother's Name: __________________________ Birth Date: ___/___/___ Soc. Security No: _____-_____-_____

Home/Cell: ______________________ Mother's Employer: ______________________________

Dental Insurance Coverage (Name of carrier): __________________________ I.D. # ________________

Whom may we thank for referring you to us? ____

Dental History

Is this the patient's first dental visit? ( ) YES ( ) NO, Approximate date of last dental visit: ___/___/___

Name of last dentist: ______________________________ Were x-rays taken at that visit? ( ) YES ( ) NO

Reason for today's visit: ____

Does the patient have any of the following habits? ( ) Thumb or finger sucking ( ) Pacifier ( ) Bottle ( ) Other: __________

Does the patient gag easily? ( ) YES ( ) N0

Has the patient ever had any pain/tenderness in their jaw joint (TMJ / TMD)? ( ) YES ( ) N0

What fluoride sources does your child receive? ( ) water supply ( ) tablets/drops ( ) toothpaste ( ) rinse/gel ( ) none

Please check any which describes your child:
( ) frightened ( ) friendly ( ) regular kid ( ) cooperative ( ) stubborn ( ) shy ( ) moody ( ) high strung ( ) defiant ( ) anxious

How has your child reacted to previous dental visits (if applicable)? ( ) positive ( ) negative

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Medical History

Patient's Name: ____

Name of patient's medical doctor or clinic:______________________________________ Phone: ___________________

Approximate date of patient's last physical exam: _____/_____/_____

Is the patient taking any **medications**? ( ) NO ( ) YES, Please list: ____

____

Does the patient have any known **allergies**? ( ) NO ( ) YES, please specify all: ___________________________________

____

Are the patient's immunizations up to date? ( ) NO ( )YES

Has the patient ever had surgery or been in the hospital over night? ( ) NO ( ) YES, Date: _____/_____/_____

Reason: ____

Does the patient have any tubes, shunts or prostheses? ( ) NO ( ) YES

Has the patient ever had any serious injuries? ( ) NO ( ) YES, please explain: ___________________________________

____

Has the patient ever been diagnosed with any of the following conditions?

NO	YES	CONDITION
		AIDS/HIV Exposure
		Asthma, Breathing, Lung problems
		Behavioral Problems ( ) Attention Deficit ( ) Autism ( ) Other:
		Blood (Bleeding) Disorders ( ) Anemia ( ) Hemophilia ( ) Sickle Cell Anemia ( ) Other:
		Blood Transfusion (specify date)
		Cancer/Radiation Therapy/Chemo
		Cerebral Palsy
		Developmentally Delayed, Functional age:
		Learning Disablility
		Diabetes
		Eye/Sight Problems
		Endocrine/Hormone Problems
		Epilepsy, Seizures, Medication?
		Frequent Infections ( ) Strep Throat ( ) Other:
		Headaches - Recurring or Frequent
		Heart Disease ( ) Murmer ( ) Congenital Defect ( ) History of Rheumatic Fever
		Hepatitis/Liver Disease/Exposure or GI Problems
		Hearing Loss/Frequent Ear Infections
		Kidney Disease
		Tuberculosisi/Exposure

Is there any other medical condition which the patient has/had that is not listed above? ( ) NO ( ) YES, please explain:

____

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of a medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

Parent or Guardian's Signature: ______________________________________ Date: ____/____/____