



Norman Cognito, 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: \_\_\_\_\_

Parent/Gaurdian Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Soc. Security No.: \_\_\_-\_\_\_-\_\_\_

Home/Cell: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent/Gaurdian Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Soc. Security No.: \_\_\_-\_\_\_-\_\_\_

Home/Cell: \_\_\_\_\_ 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 ( ) NO

Has the patient ever had any pain/tenderness in their jaw joint (TMJ / TMD)? ( ) YES ( ) NO

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 Disability
		Diabetes
		Eye/Sight Problems
		Endocrine/Hormone Problems
		Epilepsy, Seizures, Medication?
		Frequent Infections ( ) Strep Throat ( ) Other:
		Headaches - Recurring or Frequent
		Heart Disease ( ) Murmur ( ) Congenital Defect ( ) History of Rheumatic Fever
		Hepatitis/Liver Disease/Exposure or GI Problems
		Hearing Loss/Frequent Ear Infections
		Kidney Disease
		Tuberculosis/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: \_\_\_\_/\_\_\_\_/\_\_\_\_