



# IMPRESSIONS DENTAL

## Child Dental Registration & Treatment

Date \_\_\_\_\_

### *Patient Information*

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Male  Female      Date of Birth \_\_\_\_\_

School \_\_\_\_\_

The patient:  Lives with both parents     Lives with father

Lives with mother       Other \_\_\_\_\_

### *How did you hear about Impressions Dental?*

Referral \_\_\_\_\_

Mailing                       Phone Book \_\_\_\_\_

Newspaper Ad               Building Sign

Website                       Insurance company

Other \_\_\_\_\_

### *Primary Dental Insurance*

Subscriber Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS/ID # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

### *Secondary Dental Insurance*

Subscriber Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS/ID# \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_

### *Assignment and Release*

If you have dental insurance, please read below and sign.

I certify that I, and/or my dependant(s) have insurance coverage

with \_\_\_\_\_ and assign directly to  
Name of Insurance Company

Impressions Dental and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Impressions Dental and its associates may use my health care information and may disclose such information to the above named company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\*All family accounts will be linked together for financial/insurance purposes unless otherwise requested.

Signature of patient or personal representative \_\_\_\_\_

Print name of patient or personal representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_

### *Contact Information*

Father's Name \_\_\_\_\_ SS/ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

Mother's Name \_\_\_\_\_ SS/ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cellular \_\_\_\_\_

What is the best time of day and phone number to reach a parent? \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Contact Number 1 \_\_\_\_\_ Contact Number 2 \_\_\_\_\_

# IMPRESSIONS DENTAL

## Dental and Medical History Information

### Dental History

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Please check all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Bad Breath                   | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Mouth pain, brushing    |
| <input type="checkbox"/> Bleeding gums                | <input type="checkbox"/> Foreign objects               | <input type="checkbox"/> Orthodontic treatment   |
| <input type="checkbox"/> Blisters on lips or mouth    | <input type="checkbox"/> Grinding teeth                | <input type="checkbox"/> Pain around ear         |
| <input type="checkbox"/> Burning sensation on tongue  | <input type="checkbox"/> Gums swollen or tender        | <input type="checkbox"/> Periodontal treatment   |
| <input type="checkbox"/> Chew on one side of mouth    | <input type="checkbox"/> Jaw pain                      | <input type="checkbox"/> Sensitivity to cold     |
| <input type="checkbox"/> Cigarette/pipe/cigar smoking | <input type="checkbox"/> Jaw tiredness                 | <input type="checkbox"/> Sensitivity to heat     |
| <input type="checkbox"/> Clicking or popping jaw      | <input type="checkbox"/> Lip or cheek biting           | <input type="checkbox"/> Sensitivity to sweets   |
| <input type="checkbox"/> Dry mouth                    | <input type="checkbox"/> Loose teeth/broken fillings   | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Fingernail biting            | <input type="checkbox"/> Mouth breathing               | <input type="checkbox"/> Sores/growths in mouth  |

### Health History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa.  Yes  No

Please check all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Radiation Treatment             |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Respiratory Disease             |
| <input type="checkbox"/> Arthritis, Rheumatism                            | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Artificial Heart Valves                          | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Scarlet Fever                   |
| <input type="checkbox"/> Artificial Joints                                | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Shortness of Breath             |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Sinus Trouble                   |
| <input type="checkbox"/> Back Problems                                    | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Skin Rash                       |
| <input type="checkbox"/> Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Hepatitis Type _____  | <input type="checkbox"/> Special Diet                    |
| <input type="checkbox"/> Blood Disease                                    | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Swollen Feet/Ankles             |
| <input type="checkbox"/> Chemical Dependency                              | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Swollen Neck Glands             |
| <input type="checkbox"/> Chemotherapy                                     | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Thyroid Problems                |
| <input type="checkbox"/> Circulatory Problems                             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Tonsillitis                     |
| <input type="checkbox"/> Congenital Heart Lesions                         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Cortisone Treatments                             | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Tumor or growth on head or neck |
| <input type="checkbox"/> Cough, persistent/bloody                         | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer                           |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Venereal Disease                |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Weight Loss/Gain                |
|   | <input type="checkbox"/> Psychiatric Care      |  |

Do you wear contact lenses?  Yes  No      Are you taking birth control pills?  Yes  No

Are you pregnant?  Yes  No      Due Date \_\_\_\_\_      Are you nursing?  Yes  No

### Medications

List any medications you are currently taking and the correlating diagnosis: \_\_\_\_\_

### Allergies

- |   |                                     |                                       |
|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Latex      | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Metals     | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin |                                       |
| <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Sulfa      |                                       |

I authorize and give consent to perform dental services agreed between Impressions Dental and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

\_\_\_\_\_  
Signature of patient, parent, guardian or personal representative

\_\_\_\_\_  
Printed name of patient, parent, guardian, or personal representative

\_\_\_\_\_  
Date