FRANCO & ASSOCIATES
Family & Cosmetic Dentistry

REGISTRATION & HISTORY

(For Minors)

PLEASE PRINT

Biographical Data (Filled out by parent or guardian)

1. PATIENT

Name________________ Date of Birth ________ Phone ________

Nickname ________________ Sex: M ____ F ____

Pets, Hobbies ________________

Home Address ________________ City ________ State ____ Zip ________

2. PARENTS/FAMILY

Father's Name ________________ Date of Birth ________ Marital Status: S M W D Se

Place of Business ________________ Phone ________

Business Address ________________

Mother's Name ________________ Date of Birth ________ Marital Status: S M W D Se

Place of Business ________________ Phone ________

Business Address ________________

Brothers/Sisters (names and ages) ________________

3. LEGAL GUARDIAN (If other than parent)

Name ________________ Phone ________

Address ________________ City ________ State ____ Zip ________

4. PERSON RESPONSIBLE FOR THIS ACCOUNT ________________

5. INSURANCE (is your child covered by)

☐ Social Agency Agency ________________

☐ Dental Insurance

Policy Holder's Name ________ Policy Holder's DOB ________

Name of Insurance Co. ________________

Policy Number ________________

Policy Holder's Social Security Number ________________

6. ASSIGNMENT OF BENEFITS

I authorize payment of benefits, as determined by my insurance policy, directly to Franco & Associates Dentistry. I understand that I am financially responsible to Franco & Associates Dentistry for charges not paid under this assignment. A copy of this form shall be as valid as the original.

Signed: X________________
Insured Person

7. RECORDS RELEASE

I hereby authorize Franco & Associates Dentistry to release to my insurance company any information, including diagnosis and records of treatment concerning my dental care.

Signed: X________________
Patient or Guardian

8. INTEREST CHARGE AND CREDIT POLICY

All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of .66% a month for an (ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance.

My signature acknowledges that I understand this policy:

Signature: X________________ ________________ Date: ________

9. REFERRAL (If you are a new patient)

Thank you for selecting our practice. It would be helpful to know why you selected us.

☐ Referred by friend/family ________________

☐ Convenient to home/work

☐ Yellow Page Ad

☐ Referred by Doctor/Dentist ________________

☐ Saw your ad In ________________

☐ Other (specify) ________________

(See other side)

Dental History

1. Is this your child's first visit to a dentist? ☐ yes ☐ no
2. If no, give date of last examination. ______________ Dentist's Name ______________
3. Has your child ever had any of the following? Please check.
   - ☐ abscesses (gum boils)
   - ☐ cold sores (fever blisters)
   - ☐ injury to front teeth
   - ☐ frequent sore throats
   - ☐ toothaches
   - ☐ bad breath
   - ☐ stained teeth
   - ☐ bleeding gums
4. Does (or did) your child have habits which might affect oral health? If yes, check.
   - ☐ clenching or grinding teeth
   - ☐ finger or thumb habits
   - ☐ mouth breathing
   - ☐ other______________
5. Does your child have a speech problem? ☐ yes ☐ no
6. Does your child take fluoride at school? ☐ yes ☐ no

Medical History

	Yes	No
1. Does your child have any health problems? If yes, explain. ______________	☐	☐
2. Did your child have a history of health problems at birth or during infancy? If yes, explain. ______________	☐	☐
3. Is your child taking any medication or drugs at this time? Please list. ______________	☐	☐
4. Has your child ever had any unfavorable reactions to foods, drugs, or medicines? Please list. ______________	☐	☐
5. Has your child ever been hospitalized or injured? Date ______________ Reason: ______________	☐	☐
6. Does your child have any limitations to sports activities? If yes, explain. ______________	☐	☐

7. Has your child ever had any history of the following?

Condition	Yes	No
Allergies	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Heart murmur	☐	☐
Rheumatic fever	☐	☐
Congenital heart defects	☐	☐
Seizures	☐	☐
HIV/AIDS	☐	☐
Anemia	☐	☐
Excessive or prolonged bleeding	☐	☐
Fainting spells	☐	☐
Jaundice	☐	☐
Hepatitis	☐	☐
Asthma or hay fever	☐	☐
Psychiatric Care	☐	☐

Comments ______________

8. Name of pediatrician or family physician ______________
   Address ______________ Phone ______________
9. Does your child have problems in :
   ☐ concentrating ☐ learning ☐ cooperating ☐ understanding
10. Do you think your child will be a cooperative patient? ______________

I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

______________ Signature (Parent or Guardian) Date