ANDRADA AND ROSE, INC.

REGISTRATION FORM

(Please Print)

Today's date:	Pediatrician:

PATIENT INFORMATION

Patient's Last Name: First: MI:	Referral ❑ Yes ❑ No	Student ❑ Yes ❑ No	Name of School

Is it okay to Text or Email to confirm appointment? ❑ Yes ❑ No	Email:	Preferred Name:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Mailing address:	SSN:	Home #: ( ) Cell #: ( )

P.O. Box:	City:	State:	ZIP Code:

Legal Guardian/Parent DOB: / /	Legal Guardian/Parent Name (First, MI, Last):	Driver's License #:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Whom may we thank for referring you to us?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Does patient live with this person? ❑ Yes ❑ No	Driver's License #:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is the patient covered by dental insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Delta Dental ❑ BCBS ❑ CIGNA ❑ Guardian ❑ Aetna ❑ Metlife ❑ United Concordia ❑ Medicaid ❑ Humana ❑ Other

Subscriber's Name (First, MI ,Last):	Subscriber's SSN:	Birth date: / /	Employer:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name (First, MI, Last):	Subscriber's SSN:	Birth Date: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Andrada and Rose, Inc. or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

ANDRADA AND ROSE, INC.

CHILD'S HEALTH HISTORY

□ Yes □ No Is your child in good health? If no, explain _____
□ Yes □ No Has your child ever had a health problem? If yes, explain _____
□ Yes □ No Has your child ever been hospitalized? Please give reason and dates: _____
_____
_____
□ Yes □ No Is your child allergic to anything? _____
□ Yes □ No Is your child currently taking any medications? Please give medication(s), dosage and reason
_____
_____
□ Yes □ No Were there any problems at birth? _____
□ Yes □ No Any history of malignant hyper/hypothermia?
Date of last physical exam: _____

Please mark if your child has been treated for any of the following:

□AIDS/HIV	□Kidney disease/UTI	□Autism
□Cancer/tumors	□Congenital birth defects	□Down's Syndrome
□Eyesight	□Asthma/breathing/pneumonia	□Liver/GI disease
□MRSA	□Adverse drug reactions	□Cerebral palsy
□Frequent infections	□Personality/social	□Mental delays
□Cleft lip/palate	□Heart disease/murmur/surgery	□Physical delays
□Hepatitis/Jaundice	□Rheumatic fever/heart damage	□Endocrine/growth
□Reflux/GERD	□Anemia /Sickle Cell Disease	□Diabetes
□Speech/hearing	□Bleeding/transfusions (Date:_____)	□Seizures
□Blood dyscrasias	□Other problems: _____	

Do you consider your child to be:
□ advanced in the learning process □ progressing normally □ slow in the learning process
Was your child: □ breast fed □bottle fed At what age was it stopped? _____
□ Yes □ No Does your child use a sippy cup?

DENTAL HISTORY

□ Yes □ No Has your child ever been to the dentist? Date of last X-rays (if taken) _____
Name of dentist and date: _____
□ Yes □ No Has your child experienced any unfavorable reaction from previous dental care? Explain
_____
□ Yes □ No Does your child suck a finger, thumb or pacifier?
□ Yes □ No Does your child have pain with chewing, yawning, or opening wide?
□ Yes □ No Does your child's jaw make noise and is pain associated with the sounds?
Please check if your child is having problems with any of the following:
□ Cavities □ Toothache □ Teeth Sensitivity □ Trauma □ Gum Infections □ Color of teeth
□ Orthodontics □ Jaw Sounds □ Other Comments: _____