PATIENT REGISTRATION

Patient's Name: ________________________________**Patient's Birth Date:** _____________ **MALE / FEMALE**
Please Circle

Father's Name: _____________________________________**Father's Birth Date:**_________________

Mother's Name: ____________________________________ **Mother's Birth Date:** ________________

Mailing Address: ______________________________________**City:** _________________**Zip:** __________

Home Phone #: __________________**Cell Phone #:** _________________**Message #:** ________________

Nearest Relative's name: ____**Phone #:** ___________________

Referred by: ____

Best Contact Method: By phone or Text? ____

E-mail:____

If you are covered by Insurance we will need the following:

INSURANCE INFORMATION

Father's Occupation: ________________________________**Employer:**___________________________________

Work Phone:____ **Social Security No.**____________________________

Mother's Occupation: ________________________________**Employer:**___________________________________

Work Phone:____ **Social Security No.**____________________________

#1 Primary **Name of Insured:** ____

Insurance Co.: ____**Address:**___________________________________

Group #: _______________________________ **Local #:**_____________________________________

#2 Secondary **Name of Insured:** ____

Insurance Co.: ____**Address:**__________________________________

Group #: _______________________________ **Local #:**______________________________________

CREDIT INFORMATION

Responsible Party: _____________________________________

I hereby authorize Chardonnay Dental to perform dental services on the above named child. I am the parent / legal guardian.
I agree to pay all fees on the date of service unless specific financial arrangements have been made. My signature below releases assignment of Insurance Benefits to Chardonnay Dental. In the event that legal action is brought to collect amount(s) owed to Chardonnay Dental, the prevailing party shall be entitled to the award of a reasonable attorney fee, and venue shall be in Benton County, Washington.

Signature: _____________________________________**Date:** __________________________

Office Use Only:

Patient PIC # ____________________________

CHARDONNAY DENTAL

Patient Name: ______________________________ **Date:** __________

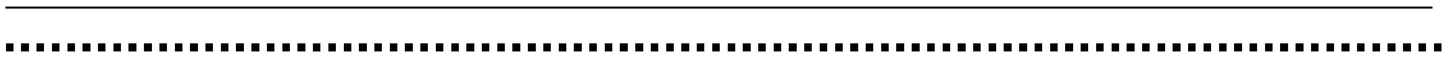
Chief Dental Complaint: ______________________________

Date of Last Dental Visit and X-rays: __________ **Name of Medical Doctor:** ______________________________

Are you taking any medications at this time? Please list: ______________________________

DO YOU HAVE A MEDICAL CONDITION THAT REQUIRES PRE-MEDICATION PRIOR TO DENTAL WORK?

____



HAVE YOU EVER BEEN DIAGONSED WITH OR TREATED FOR:

	No	Yes	Explain
Heart Disease including:			
Heart Murmur	____	____	____________
Rheumatic Fever	____	____	____________
Pace Maker	____	____	____________
Valve Replacement	____	____	____________
Heart Attack	____	____	____________
By-Pass Surgery	____	____	____________
Stroke	____	____	____________
Abnormal Blood Pressure	____	____	____________
Ulcers	____	____	____________
Tuberculosis or Lung Disease	____	____	____________
Diabetes	____	____	____________
Anemia	____	____	____________
Cancer	____	____	____________
Venereal Diseas e	____	____	____________
Asthma or Hay Fever	____	____	____________
Hepatitis	____	____	____________
Arthritis	____	____	____________
Joint Replacement	____	____	____________
HIV positive (Aids)	____	____	____________
Cocaine or Street Drug User?	____	____	____________
Seizures	____	____	____________
Developmental Delay	____	____	____________
ADD/ ADHD/ Sensory Disorder	____	____	____________
ARE YOU ALLERGIC TO:			
Penicillin	____	____	____________
Codeine	____	____	____________
Local Anesthesia	____	____	____________
Sulfa	____	____	____________
Latex	____	____	____________
Other Allergies?	____	____	____________
Are you subject to prolonged bleeding?	____	____	____________

Are you pregnant? **No**________ **Yes** ____ **Date Due**______________________

Other medical complications?