ST. PETE MODERN DENTISTRY
Say goodbye to dental anxiety

Dr. Elena Gutu
5500 1st Ave. North
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(727) 954-4431

## CHILD Registration Form

**Patient Name:** _____ **Date:** _____
Last Name First MI Preferred Name

**Home Address:** _____

**Birth Date:** _____ **Sex:** _____ **Name of School Attending:** _____

**Social Security Number:** _____

**Mother's Name:** _____ **Father's Name:** _____

**Contact #'s Home:** _____ **Best time to call:** _____

**Names of immediate family members:** _____

**Nearest Relative:** _____ **Phone:** _____

**Perferred Appointment Times:** ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

**Email Address:** _____

## Health Information

**Previous Dentist:** _____ **Date of Last Dental Visit:** _____

**Reason for this visit:** _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artifical Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Mitral Valve Prolapse
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type:
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

**Please list all medications you are now taking:** _____

**Have you ever had any complications following dental treatment?** ☐ **Yes** ☐ **No**
**If yes, please explain:** _____

**Have you ever been admitted to a hospital or needed emergency care during the past two years?** ☐ **Yes** ☐ **No**
**If yes, please explain:** _____

**Are you now under the care of a physician?** ☐ **Yes** ☐ **No**
**If yes, please explain:** _____

**Name of Physician:** _____

**Do you have any health problmes that need further clarification?** ☐ **Yes** ☐ **No**
**If yes, please explain:** _____

**Whom may we thank for referring you to our practice?** _____

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the doctors at the next appointment without fail.**

_____ _____
Signature of patient, parent or guardian Date

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## Responsible Party Information

**Name of person financially responsible:** _____
**Relationship to patient:** _____
**Social Security #** _____ **Birthdate:** _____
**Address:** _____
**City, State & Zip Code:** _____

## Employment Information

**Employer Name:** _____ **Occupation:** _____
**Employers Address:** _____ **Phone:** _____
**Spouse Employer:** _____ **Occupation:** _____
**Employers Address:** _____ **Phone:** _____

## Insurance Information

**Primary**

**Name of Insured:** _____ **Is insured a patient?** ☐ **Yes** ☐ **No**
**Insured's Birth Date:** _____ **Insured's Social Security Number:** _____
**Insurance ID #:** _____ **Group #:** _____
**Insured's Address:** _____
**Insured's Employer Name:** _____
**Patient's relationship to insured:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**
**Insurance Plan Name and Address:** _____

**Secondary**

**Name of Insured:** _____ **Is insured a patient?** ☐ **Yes** ☐ **No**
**Insured's Birth Date:** _____ **Insured's Social Security Number:** _____
**Insurance ID #:** _____ **Group #:** _____
**Insured's Address:** _____
**Insured's Employer Name:** _____
**Patient's relationship to insured:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**
**Insurance Plan Name and Address:** _____