RICARDO C. GUILLEN, D.D.S., P.L.L.C.

rev. 12/14

PATIENT REGISTRATION AND MEDICAL HISTORY FOR MINORS

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can (please print). If you have questions, we will be glad to help you. We look forward to working with your child.

1. Child's Name_____ Date _____ ☐ M ☐ F DOB _____

2. Father's Name _____DOB _____Driver's Lic. #_____St. _____

S/S#_____/_____/_____ PHONE# H_____W_____X_____C_____

Address_____ City_____ St_____ Zip_____

3.Mother's Name _____DOB _____Driver's Lic. #_____ St. _____

S/S#_____/_____/_____ Phone# H_____W_____X_____C_____

Address_____City_____St_____ Zip_____

4. Emergency Contact (Other Than Parent) _____Phone # _____

5. Person Responsible For Payment on Acct _____ Email _____

6. How did you hear about us? _____

7. Primary Insurance Co. _____ID# _____Group # _____

Subscriber's Name _____ DOB _____S/S/# _____/_____/_____

Relationship to Child _____ Is Child covered by Additional Insurance? ☐ Yes ☐ No **Please present your Ins. Card if available**.

(If Insurance arrangements are included in a Divorce Decree/ Custody Document – Additional forms must be completed)

8.Secondary Insurance Co. _____ID# _____Group # _____

Subscriber's Name _____ DOB _____ S/S# _____/_____/_____

Address _____Rel. to Patient_____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Mauldin 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits and authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Must be Parent/Guardian | Relationship | Date

DENTAL HISTORY

HAS YOUR CHILD EVER BEEN TOLD THAT PREMEDICATION IS REQUIRED FOR A DENTAL PROCEDURE? ☐ Yes ☐ No

9.Reason for Today's Visit _____Former Dentist _____

Phone # _____ Date of Last Dental Exam _____/_____/_____Last X-rays _____/_____/_____

10. Place a mark on "yes" or "no" to indicate if your child has had any of the following::

Bad breath	☐Yes ☐ No	Foreign objects	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Gums swollen	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Loose or broken teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No	Loose fillings	☐ Yes ☐ No	Sores, growths in mouth	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	How often do you brush ?_____	
Fingernail biting	☐ Yes ☐ No	Mouth pain with brushing	☐ Yes ☐ No	Floss? _____	

MINORS HEALTH HISTORY

CHILD'S PHYSICIAN _____ DATE OF LAST VISIT _____

11. Place a mark on "yes" or "no" to indicate if your child has had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Atopic (Allergy Prone)	☐ Yes ☐ No	Hearing Impaired	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally with		Hepatitis Type _____	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Swollen feet or ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen neck glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Tumor/growth on head/neck	☐ Yes ☐ No
Congenital heart lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐No
Cough, persistent or		Mitral Valve Prolapse	☐ Yes ☐ No	Weight loss, unexplained	☐ Yes ☐ No
bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	H.P.V.	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Guardasil Vaccination	☐ Yes ☐ No

Has your child ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Is there anything else we should know about your child's medical history? _____

MEDICATIONS

12. Pharmacy Name: _____ Phone: _____

List any medications your child is currently taking and the correlating diagnosis:

_____

_____

_____

List any herbs or vitamins your child is currently using:

_____

ALLERGIES

13. Check any known allergies:

Aspirin ☐ Codeine☐ Epinephrine ☐ Food ☐ Iodine☐ Latex ☐ Penicillin ☐ Sulfa ☐

Others: _____

14. To the best of my knowledge the above information is complete and correct. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment.

I understand it is my responsibility to inform the dentist if my child has a change in health.

_____ _____

Responsible Party Signature (Parent or Guardian) Date