JOSEPH DOCTORA, D.D.S., M.D. MINOR PATIENT REGISTRATION

Please Print Date

Patient Information

Name_____ Preferred Name_____
Last First Middle Maiden

Address_____ City/State/Zip_____
Number / Street

❑ Male ❑ Female Date of Birth ____/____/____

Social Security Number_____ ❑ Single ❑ Married ❑ Divorce ❑ Separated ❑ Widowed

Mother's Name_____ Date of Birth _____
Last First Middle Maiden

Address_____ City/State/Zip_____
Number / Street

Home Number(____)_____ Work Number(____)_____ Social Security Number_____

Cell Number(____)_____ Pager Number(____)_____ E-mail _____

Employer Name_____ Position_____

Employer Address_____
Street Number City/State/Zip

Father's Name_____ Date of Birth _____
Last First Middle

Address_____ City/State/Zip_____
Number / Street

Home Number_____ Cell Number_____ Social Security Number _____

Employer Name_____ Work Number (____)_____ Position_____

Employer Address_____
Street Number City/State/Zip

Responsible Party(if not parent)_____ Relationship to Patient_____

Address_____ City/State/Zip_____
Number / Street

Home Number(____)_____ Work Number(____)_____ Social Security Number_____

Employer Name_____ Position_____

Employer Address_____
Street Number City/State/Zip

Primary Insurance

Insurance Company _____ Group Number_____ Phone Number _____

Address_____ Relationship to Insured_____
Street Number City/State/Zip

Name of Insured_____ Insured's ID#_____ Insured's DOB___/___/___

Medical Insurance

Insurance Company _____ Group Number _____ Phone Number _____

Address_____ Relationship to Insured_____
Street Number City/State/Zip

Name of Insured_____ Insured's ID#_____ Insured's DOB___/___/___

Miscellaneous Information

Whom may we thank for referring you _____

Emergency Contact/Name/Phone Number_____

Nearest Relative/Name/Phone Number/Relationship*(not living with you)*_____

Family Members/Friends seen by us_____

_____ _____
Parent/Guardian/Responsible Party *Date*

OM Specialists

Medical History

Are you in good health? Yes☐ No☐

Has there been any change in you health over the last year? Yes☐ No☐

Are you under the care of a physician? Yes☐ No☐

Name of physician _____ Phone (___)___-____

Have you had any serious illness, operation or hospitalization within 5 years? Yes☐ No☐

Are you presently taking medicine(s) including non-prescription, homeopathic, or natural remedies including diet pills? (Please list below)

Drug:	Reason:
_____	_____
_____	_____
_____	_____

Are you allergic to any of these medications?

Local anesthetics	Yes☐ No☐	Codeine/Narcotics	Yes☐ No☐
Penicillin/Antibiotics	Yes☐ No☐	Latex/Rubber Products	Yes☐ No☐
Sulfa Drugs	Yes☐ No☐	Iodine	Yes☐ No☐
Barbiturates/Sleeping Pills	Yes☐ No☐	Other	Yes☐ No☐
Aspirin	Yes☐ No☐		

Do you have or ever had any of the following?

High Blood Pressure	Yes☐ No☐	Heart Disease	Yes☐ No☐	Liver Disease	Yes☐ No☐
Heart Attack	Yes☐ No☐	Cardiac Pacemaker	Yes☐ No☐	Arthritis	Yes☐ No☐
Heart Murmur	Yes☐ No☐	Chest Pain	Yes☐ No☐	Epilepsy	Yes☐ No☐
Anemia	Yes☐ No☐	Stroke	Yes☐ No☐	Leukemia	Yes☐ No☐
Rheumatic Fever	Yes☐ No☐	Angina	Yes☐ No☐	Diabetes	Yes☐ No☐
Swollen Ankles	Yes☐ No☐	Fainting, Seizures	Yes☐ No☐	Kidney Disease	Yes☐ No☐
Asthma	Yes☐ No☐	Tuberculosis	Yes☐ No☐	Hepatitis A B C	Yes☐ No☐
Frequently Tired	Yes☐ No☐	Cancer	Yes☐ No☐	AIDS/HIV	Yes☐ No☐
Emphysema	Yes☐ No☐	Ulcers	Yes☐ No☐	Resp. Problems	Yes☐ No☐
Mitral Valve Prolapse	Yes☐ No☐	STD	Yes☐ No☐	Other	Yes☐ No☐
Thyroid Problem	Yes☐ No☐	Glaucoma	Yes☐ No☐		

Have you had any serious trouble with previous dental treatments? Yes☐ No☐

If so, please explain _____

Do you have any other condition or disease you think the doctor should know about? Yes☐ No☐

If so, please explain _____

Do you use tobacco? Yes☐ No☐

Have you previously or presently used drugs or alcohol? Yes☐ No☐

WOMEN ONLY

Are you pregnant or think you may be? Yes☐ No☐ Are you nursing? Yes☐ No☐ Are you using birth control pills? Yes☐ No☐

CONSENT

I, the undersigned, certify that I (or my dependent) have insurance coverage and are assigning directly to Dr. Joseph Doctora 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 payment of benefits. I authorize the use of this signature on all insurance submissions. I have read and understand the above information.

Signature (Parent of Minor) _____ Date ____/____/_____