Medical History

Date:_____

Does your child now have or have you ever had any of the following:

	Yes	No	Don't know
Bleeding disorders, anemia.....	___	___	___
Diabetes.....	___	___	___
Liver disease, hepatitis.....	___	___	___
Heart Disease.....	___	___	___
Heart murmur.....	___	___	___
Heart surgery.....	___	___	___
Pacemaker.....	___	___	___
High blood pressure.....	___	___	___
Rheumatic Fever.....	___	___	___
Prosthetic replacement of any joint.....	___	___	___
Sinus disease.....	___	___	___
Radiation treatment.....	___	___	___
Chemotherapy.....	___	___	___
Lupus.....	___	___	___
Allergy to any medicines.....	___	___	___
Allergy to any antibiotics.....	___	___	___
Medical condition requiring hospitalization.....	___	___	___
Medical condition treated by your physician.....	___	___	___
Pregnancy (check only if you are expecting now).	___	___	___

Please answer these questions. Use the space below if you need more.

Please list any medicines your child is taking._____
Has your child ever been hospitalized? If so, for what?_____
Is your child receiving treatment from your physician? If so, for what?_____
Who is your child's physician? Where is the office?_____
What is the reason for this visit?_____

Signature:_____Date:_____

Please complete both sides.

Child Registration

Today's Date:_____
Child's Name:_____
Birthdate:_____Age:_____Male:_____Female:_____
Parent's Name:_____
Residence Address:_____
City:_____State:_____Zip:_____
Mailing Address:_____
City:_____State:_____Zip:_____
Child's social security number:_____
Phone-home:_____Phone-Cell:_____
Mother's Employer:_____Work Telephone:_____
Father's Employer:_____Work Telephone:_____
How would you prefer to be contacted for appointment confirmation?
___Phone ___Text ___Email
Who will pay this account ?_____

Insurance Information

Name and address of dental insurance company:
Primary:_____
_____
Policy#_____
Name of insured:_____Date of birth:_____
Social Security number of insured:_____
Secondary:_____
_____
Policy#_____
Name of insured:_____Date of birth:_____
Social Security number of insured:_____

I will review proposed treatment plans and authorize release of any information related to insurance claims. I understand that I am responsible for all costs of dental treatment.
Sign:_____Date:_____
I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. McGinn.
Sign:_____Date:_____

Please complete both sides.