YOUTH REGISTRATION

Nelson J. Mar, DDS

Date _____

Name of Patient_____ SS# _____
First Middle Last

Date of Birth_____ Age _____Home #(___)_____

Father's Full Name_____SS#_____Work #(___)_____

Mother's Full Name_____SS#_____Work #(___)_____

Fax # (_____)_____E-Mail Address _____

Home Address_____Zip_____

Past Dental Service (check): None_____ Emerg. only_____ Regular_____ First Visit_____

Favorite Name or Nickname_____ Outside or Special Interest_____

School_____ School Grade_____

Person Responsible for Account _____ Relationship_____

Social Security Number_____Occupation_____

Employer_____Work # (___)_____

Employer's Address_____

Do you have Dental Insurance? Yes_____ No_____ With Whom?_____

Nearest Relative Not Living With You_____ Relationship_____

Address_____Zip_____Phone #(___)_____

Recommended By_____Patient's Physician_____

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office. Please circle yes or no to the following:

1. Is the patient presently under the care of a physician..... Yes No
2. Has the patient ever had abnormal bleeding following a wound?..... Yes No
3. Is the patient allergic to Penicillin, Novocain or any other medication?..... Yes No
   If so, what?_____
4. Is the patient allergic to anything other than medicine? (e.g. latex or metals)?..... Yes No
   If so, what?_____
5. Is the patient presently taking any medication?..... Yes No
   If so, what?_____
6. Does the patient have any limiting disabilities?..... Yes No
   If so, what?_____
7. Has the patient ever had any of the following?

a)	Rheumatic Fever	Yes	No	h)	Tuberculosis	Yes	No
b)	Rheumatic Heart Disease	Yes	No	i)	Diabetes	Yes	No
c)	Congenital Heart Disease	Yes	No	j)	Liver Trouble or Jaundice	Yes	No
d)	Blood Disorder	Yes	No	k)	Heart Murmur	Yes	No
e)	Epilepsy or Convulsions	Yes	No	l)	Hepatitis	Yes	No
f)	Asthma or Hay Fever	Yes	No	m)	Eczema or Hives	Yes	No
g)	Mitral Valve Prolapse	Yes	No	n)	HIV (Aids)	Yes	No

8. Does the patient have any history of missing teeth?..... Yes No
9. Has the patient been under the care of a physician for any major illness or injury other than those noted above..... Yes No
   If so, what?_____

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment for the child named above in my absence.

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

_____ _____
Signature of Parent or Guardian Date

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Rev. 24-Jan-03

Our office is committed to meeting or exceeding the standards of injection control mandated by the OSHA, the CDC and the ADA.

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