Yangsun (Paul) Bak, D.D.S.

WINDWARD
PEDIATRIC DENTISTRY, P.C.

Rachel K. Keleske, D.D.S.

CHILD'S REGISTRATION

Patient Name: _____ Birth Date: ____/____/____
First Middle Last

Patient Name: _____ Birth Date: ____/____/____
First Middle Last

Patient Name: _____ Birth Date: ____/____/____
First Middle Last

Patient Name: _____ Birth Date: ____/____/____
First Middle Last

Patient lives with: ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Other:** _____

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Father's Name: _____
First Middle Last

Street Address: _____

City: _____ Zip: _____

S.S.#:: _____ DOB: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Employer: _____

Occupation: _____

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Mother's Name: _____
First Middle Last

Street Address: _____

City: _____ Zip: _____

S.S.#:: _____ DOB: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Employer: _____

Occupation: _____

Who is Accompanying the Child Today?

Name: _____
First Middle Last

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

DENTAL INSURANCE INFORMATION

Subscriber Name: _____

Ins. Co. Name: _____

Group Plan/Employer's Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Insured ID #: : _____

Tel: (770) 344-0170 / Fax: (770) 344-0169 ■ 11730 Jones Bridge Rd. Suites B,C & D, Alpharetta, GA 30005

HEALTH HISTORY

Date: _____

Child's Name: _____ Nick Name: _____

Age: _____ Date of Birth: _____ ☐ Male ☐ Female

MEDICAL HISTORY

Pediatrician: _____ Phone: _____

Date of last physical: _____

Is your child in good health? ☐ Yes ☐ No Are immunizations up to date? ☐ Yes ☐ No

Is your child taking any medications? ☐ Yes ☐ No Please list:

Please circle (Yes) or (No) regarding your child's history of the following:

Y	N	Allergies (Environmental)	Y	N	Cancer / Tumors	Y	N	HIV / AIDS
Y	N	Allergies (Foods / Dyes)	Y	N	Cleft Lip / Palate	Y	N	Hyperactivity / ADD / ADHD
Y	N	Allergies to Medications	Y	N	Diabetes	Y	N	Hospitalizations / Surgery
Y	N	Latex Allergy	Y	N	Epilepsy / Seizures	Y	N	Kidney Disease
Y	N	Anemia / Bleeding Problems	Y	N	Growth / Development Problems	Y	N	Rheumatic Fever
Y	N	Asthma	Y	N	Hearing / Speech Problems	Y	N	Sickle Cell Disease
Y	N	Autism / PDD	Y	N	Heart Murmur / Heart Disease			
Y	N	Birth Defects / Disabilities	Y	N	Hepatitis / Liver Disease			

If you answered Yes to any of the above, please explain: _____

_____

Other medical information we should know about your child: _____

_____

DENTAL HISTORY

Previous Dentist: _____ Date of Last Visit: _____

Reason for leaving previous dentist: _____

Reason for today's visit: _____

Does your child brush daily? ☐ Yes ☐ No How Often? _____

Floss their teeth daily? ☐ Yes ☐ No Do you help your child brush and floss? ☐ Yes ☐ No

Has your child had any injuries to the teeth, mouth or jaws? ☐ Yes ☐ No _____

Has your child had or have any of the following habits?

Y	N	Thumb / Finger Sucking	Y	N	Nail Biting	Y	N	Snoring
Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits / Pacifier	Y	N	Grinding

To the best of my knowledge, the above information is complete and accurate. I understand that this information may be disclosed in treatment, for payment, and in normal healthcare operations. I understand that I am responsible for any financial obligation incurred for the services provided.

Signature _____ Relationship _____ Date _____

Reviewed by Doctor _____