RALPH E. WYAND, D.D.S.
PEDIATRIC DENTISTRY

REGISTRATION

DATE ______________________

CHILD'S FULL NAME ____
FIRST MIDDLE LAST NICKNAME

AGE: ______________ DATE OF BIRTH ______________ SEX: MALE ❒ FEMALE ❒

* * * * * * * * * * * * * * * *

DOES YOUR CHILD HAVE PETS, HOBBIES OR PARTICULAR INTERESTS? ______________________

NAMES AND BIRTHDATES OF BROTHERS AND SISTERS: ______________________

IS YOUR CHILD ADOPTED? ______________ HAS YOUR CHILD BEEN TOLD? ______________

IN YOUR OPINION IS YOUR CHILD SHY ❒ AVERAGE ❒ AGGRESSIVE ❒

IF YOUR CHILD IS IN SCHOOL: NAME OF SCHOOL ______________________ GRADE ________

SCHOLASTIC PROGRESS: BELOW AVERAGE ❒ AVERAGE ❒ ABOVE AVERAGE ❒

* * * * * * * * * * * * * * * *

PARENTS FULL NAMES ____

MARRIED ❒ SEPARATED ❒ WIDOWED ❒ DIVORCED ❒ REMARRIED ❒ SINGLE ❒

RESIDENCE ADDRESS: ____
STREET CITY STATE ZIP

RESIDENCE TELEPHONE ______________ ALTERNATE DAYTIME TELEPHONE ______________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT: ______________ RELATIONSHIP: ________

ADDRESS (if different from above): ______________________________

EMPLOYED BY: ______________________ HOW LONG?: ______________

OCCUPATION/POSITION: ______________________ WORK PHONE: ______________

IS SPOUSE EMPLOYED? ________ If YES, Employer Name: ______________________

HOW LONG ______________ WORK PHONE: ______________________

HOW WERE YOU REFERRED TO THIS OFFICE? ______________________________

* * * * * * * * * * * * * * * *

PRIMARY DENTAL INSURANCE COMPANY: ______________________________

INSURANCE ADDRESS: ____
STREET CITY STATE ZIP

INSURANCE TELEPHONE: ______________ INSURANCE FAX (if applicable) ______________

INSURED NAME: ______________ PATIENT'S RELATIONSHIP TO INSURED: ______________

SOCIAL SECURITY #: ______________ SEX: ________ DATE OF BIRTH: ______________

IDENTIFICATION #: ______________ GROUP POLICY #: ______________

EMPLOYER NAME: ______________ WORK PHONE: ______________

IS THERE A SECONDARY INSURANCE? NO ______ YES ______ IF SO, PLEASE PRINT INFORMATION ON BACK OF THIS SHEET.

* * * * * * * * * * * * * * * *

I authorize release of any information necessary to process my Insurance claims. I assign and request payment directly to Dr. Ralph E. Wyand D.D.S.

SIGNATURE ______________________________ DATE: ______________________

RALPH E. WYAND, D.D.S.
PEDIATRIC DENTISTRY

DENTAL AND MEDICAL HISTORY

DATE________________________________

CHILD'S FULL NAME____
FIRST MIDDLE LAST

NAME OF CHILD'S PHYSICIAN (M.D.)____

PHYSICIAN'S ADDRESS ______________________________ PHONE NO.____________________

1. DOES YOUR CHILD HAVE ANY CAVITIES OF WHICH YOU ARE AWARE? YES_____ NO_____
   HAS YOUR CHILD EXPERIENCED A TOOTHACHE OR DISCOMFORT? YES_____ NO_____
   EXPLAIN______________________________
   HAS YOUR CHILD HAS ANY INJURIES TO THE MOUTH OR TEETH? YES_____ NO_____
   EXPLAIN______________________________
   IS THERE ANYTHING YOU ARE CONCERNED ABOUT IN YOUR CHILD'S MOUTH? YES_____ NO_____
   EXPLAIN______________________________
2. HAS YOUR CHILD EVER BEEN EXAMINED OR TREATED BY A DENTIST? YES_____ NO_____
   DATE OF THE LAST VISIT______________________________
   NAME AND LOCATION OF DENTIST______________________________
3. IS YOUR CHILD FEARFUL OR APPREHENSIVE ABOUT THIS DENTAL VISIT? YES_____ NO_____
4. DOES YOUR CHILD HAVE ANY HABITS THAT MIGHT AFFECT THE MOUTH OR TEETH? PLEASE CHECK:
   __SUCKS THUMB OR FINGER __SNORING AT NIGHT __BITES FINGER NAILS
   __BREATHES THROUGH MOUTH __TONGUE HABITS __USES PACIFIER
   __GRINDS TEETH __BITES OR SUCKS LIPS __USES NURSING BOTTLE
   __OTHER
5. IS THE WATER WHERE YOU LIVE FLUORIDATED? YES_____ NO_____
   DO YOU USE BOTTLED WATER OR FILTERED WATER?____________________
   DOES YOUR CHILD TAKE A DAILY FLUORIDE VITAMIN OR FLUORIDE TABLET? YES_____ NO_____
6. IS YOUR CHILD KNOWN TO BE SENSITIVE OR ALLERGIC TO ANY DRUG? YES_____ NO_____
   GIVE NAME OF DRUG______________________________ YES_____ NO_____
7. DOES YOUR CHILD HAVE ANY KNOWN ABNORMAL BLEEDING TENDENCIES? YES_____ NO_____
8. DOES YOUR CHILD HAVE ANY PHYSICAL OR MENTAL HANDICAPS? YES_____ NO_____
   EXPLAIN______________________________
9. DOES YOUR CHILD HAVE, OR HAS HE/SHE EVER HAD:

HEART TROUBLE	YES ___	NO ___	KIDNEY INVOLVEMENT	YES ___	NO___
RHEUMATIC FEVER	YES ___	NO ___	LIVER INVOLVEMENT	YES ___	NO___
DIABETES	YES ___	NO ___	CONVULSIONS	YES ___	NO___
ASTHMA	YES ___	NO ___	ANY OTHER DISORDER	YES ___	NO___
TUBERCULOSIS	YES ___	NO ___	AIDS (IMMUNOSUPPRESSIVE DISORDER)	YES ___	NO___

COMMENTS:____

10. IS YOUR CHILD BEING TREATED BY A PHYSICIAN FOR ANY CONDITION? YES_____ NO_____
    EXPLAIN (IF ANSWER IS YES) ______________________________
11. IS YOUR CHILD TAKING ANY MEDICINES? YES_____ NO_____
    IF YES, WHAT IS HE/SHE TAKING AND FOR WHAT PURPOSE?____________________
12. HAS YOUR CHILD EVER BEEN HOSPITALIZED FOR ANY ILLNESS OR SURGERY? YES_____ NO_____
    EXPLAIN (IF YOUR ANSWER IS YES) GIVE DATES AND NAME OF HOSPITAL

FORMS COMPLETED BY:______________________ RELATIONSHIP TO PATIENT:______________________

SIGNATURE:____