STEVEN E GREER, D.D.S.

2991 Treat Blvd, Suite G
Concord, CA 94518
(925) 689-7110

PATIENT REGISTRATION FORM
- CHILD -

CHILD'S NAME:_____ **NICKNAME:**_____

DATE OF BIRTH: ____/____/_____ **SCHOOL:**_____

ADDRESS:_____ **CITY:** _____ **ZIP:**_____

FATHER'S NAME:_____ **DRIVER'S LIC #**_____ **SS#**_____

MOTHER'S NAME:_____ **DRIVER'S LIC #**_____ **SS#**_____

Do the father, mother and child live together? Y / N If No, please explain who will be responsible for financial arrangements:_____

PRIMARY TELEPHONE (C) (H) (W)_____
May we text you to confirm appointments: Y / N

SECONDARY TELEPHONE (C) (H) (W)_____

EMAIL:_____
May we email you to confirm your appointments? Y / N

Emergency Contact: _____ **Phone:**_____

Whom may we thank for referring you?_____

CONSENT FOR TREATMENT

I hereby authorize and request Dr. Greer and staff to perform procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition. I also certify that my medical and dental history was carefully considered and complete information was given.

I understand it is my sole responsibility for all treatment costs and, if I have dental insurance, I will authorize payment to Dr. Steven E. Greer and I will accept full financial responsibility for any balance remaining after my dental insurance is paid.

_____ _____

Patient Signature **Date**

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Employee & relationship to Child: _____

Name & City of your Employer: _____

Insurance Company: _____

Primary Insured's SS#: _____ **Insured's Date of Birth:** _____

SECONDARY INSURANCE INFORMATION

Spouse's Name: _____ **Business Phone #:** _____

Name & City of Spouse's Employer: _____

Name of Spouse's Dental Insurance Company: _____

Spouse's Birthday: _____ **Spouse's SS#:** _____

MEDICAL / DENTAL HISTORY

Is the first visit to the Dentist? Y / N **Last Dental Visit:** _____

Dentist's Name: _____

Are you experiencing any discomfort at this time? If so, please explain: _____

_____

_____

_____

Have you ever had your teeth straightened? Y / N When: _____

Have you ever had gum treatment or bone surgery? Y / N When: _____

Orthodontist: _____ **Periodontist:** _____

DENTAL HISTORY CONTINUED

Does your family have a history of dentures or tooth loss due to periodontal disease? Y / N

If yes, please explain: _____

_____

_____

Have you ever had any serious injury to your face or jaw? Y / N

If yes, please explain: _____

_____

_____

How do you feel about the appearance of your teeth? _____

_____

Do you like the color of your teeth? _____

24-HOUR CANCELLATION POLICY

I understand the office of Steven E. Greer, D.D.S., strives to provide the best care possible. Making my appointments on time is essential towards providing me with the best dental treatment possible. If I need to reschedule my appointment, I understand that I need to give 24 hours notice.

Signature: _____ **Date:** _____

MEDICAL HISTORY

Is your child in good health? Y / N If No, please explain: _____

_____

_____

Primary Physician's Name: _____ **Phone #:** _____

Are you a member of Kaiser: Y / N _____ **If so, what is your Medical Record #:** _____

Date of most recent physical examination: _____

Does your child have or have ever had in the past:

Heart Problems	**Y / N**	**Fainting:**	**Y / N**
Describe: _____		**Epilepsy:**	**Y / N**
Pacemaker/Defibrillator	**Y / N**	**Seizures**	**Y / N**
Heart Murmur	**Y / N**	**Date of last seizure:** _____	
Rheumatic Fever	**Y / N**	**Sinus Problems**	**Y / N**
Mitral Valve Prolapse	**Y / N**	**Cancer or Tumors**	**Y / N**
With Regurgitation	**Y / N**	**Radiation Treatment**	**Y / N**
Bacterial Endocarditis	**Y / N**	**Anemia**	**Y / N**
High Blood Pressure	**Y / N**	**Arthritis**	**Y / N**
Diet Pills (e.g. Fen-Phen)	**Y / N**	**Excessive Bleeding**	**Y / N**
Stroke	**Y / N**	**Frequent Headaches**	**Y / N**
Diabetes	**Y / N**	**Skin Disease**	**Y / N**
Asthma	**Y / N**	**Kidney Problems**	**Y / N**
Psychiatric Care	**Y / N**	**Joint Replacement**	**Y / N**
Ulcer / Stomach Problems	**Y / N**	**Name of Orthopedic Surgeon:**	
Bulimia / Anorexia	**Y / N**	_____	
Hepatitis	**Y / N**	**AIDS/ ARC/ HIV**	**Y / N**
Alcohol / Drug Recovery	**Y / N**	**Venereal Disease**	**Y / N**
Organ Transplant	**Y / N**	**Herpes / Cold Sores**	**Y / N**
Allergy to local anesthetic	**Y / N**	**Allergy to Penicillin**	**Y / N**
Allergies to medicines or drugs?	**Y/ N**	**Tuberculosis**	**Y / N**

List Allergies: _____

List all medications taken on a regular basis* (please include dosage)

_____

_____

(* It is important that you list all drugs you take - prescription and/or non prescription - and the amount/dosage you are taking, since some drugs will react poorly with medications required during your dental treatment)

Any complications after tooth extractions?	**Y / N**
Women: Are you pregnant?	**Y / N**
Women: Do you take birth control pills?	**Y / N**

Do you have any condition not listed above that we should know about? Please describe any current medical treatment, impending operations, unintentional weight loss/gain, swelling, sores, infections, or any other medical or dental information that may possibly affect your dental treatment:

_____

_____

_____