# Recall Patient Registration Form

Fòm anrejistreman pou pasyan ki retounen

Today's Date:_____ Patient (Child's) Name: _____
*Dat jodi a* *Non pasyan (timoun nan)*
Date of Birth:_____ Age:_____ Reason for Visit: ❑ Recall ❑ Other_____
*Dat nesans* *Laj* *Rezon pou vizit la* *Retounen* *Lòt*
Child's Pediatrician:_____ Phone: _____
*Pedyat timoun nan* *Telefòn*
Your Name:_____ Date of Birth: _____
*Non w* *Dat nesans*
**Your relationship to patient**:_____
*Sa w ye pou pasyan an*
Street Address:_____ City:_____ State:_____ Zip: _____
*Adrès* *Vil* *Eta* *Kòd postal*
Home Phone:_____ Cell Phone:_____ Work Phone:_____
*Nimewo telefòn nan kay la* *Telefòn selilè* *Telefòn travay*
Email:_____ Driver's License #: _____
*Imèl* *Nimewo lisans chofè*
**Preferred contact method? (circle as applicable)** E-mail Text Home Phone Cell Phone Work Phone
*Metòd ou prefere pou yo kontakte w?* *Imèl* *Tèks* *Telefòn lakay* *Telefòn selilè* *Telefòn travay*

## Patient Medical and Dental History

*Antesedan medikal ak dantè pasyan an*

Does your child have a history of **ANY** of the following medical conditions below? Please check **ALL** that apply.
*Èske pitit ou a te janm genyen **NENPÒT** nan pwoblèm medikal ki pral site anba a? Tanpri tyeke **TOUT** sa ki aplikab.*

❑ **NONE OF THE BELOW APPLY *(ANBA SA PA APLIKE)***

- ❑ Heart Disease *Maladi kè*
- ❑ Organ Transplant *Grèf ògàn*
- ❑ HIV/AIDS *VIH/SIDA*
- ❑ Sickle Cell Disease *Maladi anemi falsifòm*
- ❑ Rheumatic Fever *Rimatis atikilè egi*
- ❑ Endocarditis *Endokadis*
- ❑ Diabetes (Type I or II) *Dyabèt (Tip I oswa*
- ❑ Cerebral Palsy *Enfimite motris serebral*
- ❑ Tuberculosis *Tibèkiloz*
- ❑ Seizures/Epilepsy *Kriz/malkadi*
- ❑ Hepatitis Type A/B/C *Epatit tip A/B/C*
- ❑ Cystic Fibrosis *Mikovisidoz*
- ❑ Liver/Kidney Disease *Maladi fwa/ren*
- ❑ Sleep Apnea *Apne somèy*
- ❑ Abnormal Bleeding/ Hemophilia/Thalassemia *Sèyman anòmal/emofili/talasemi*
- ❑ History of Cardiac Surgery *Antesedan operasyon kadyak*
- ❑ History of Blood Transfusions/Dialysis *Antesedan transfizyon san/dyaliz*
- ❑ Bone Marrow Transplant *Grèf mwèl ose*
- ❑ History of Cancer/Tumors *Antesedan kansè/timè*

**The conditions in this box <u>may</u> require medical consultation and antibiotic prophylaxis.**
*Pwoblèm ki site nan bwat sa a ka nesesite konsiltasyon medikal ak pwofilaksi antibyotik.*

- ❑ Innocent Heart Murmur *Souf kadyak*
- ❑ Asthma *Opresyon*
- ❑ GI Disorders/Reflux *Twoub/refli GE*
- ❑ ADHD *TDA*
- ❑ Autism *Otis*
- ❑ Down's Syndrome *Sendwòm Down*
- ❑ Developmental Delay *Reta nan devlopman*
- ❑ Psychiatric Illness *Maladi sikyatrik*
- ❑ Drug/Alcohol/Tobacco use *Izaj dwòg/alkòl/tabak*
- ❑ Spina Bifida *Spina bifida*
- ❑ Visual/Auditory impaired *Defisyans vizyèl/oditif*
- ❑ Speech Impediment *Twoub elokisyon*
- ❑ Recurrent Ear Infections *Enfeksyon zòrèy repete*
- ❑ Whooping Cough *Koklich*
- ❑ Eating Disorder *Twoub alimantasyon*
- ❑ Dizziness/Fainting *Vètij/evanouyisman*
- ❑ Genetic Disorder *Twoub jenetik*
- ❑ Pregnant (Currently) *Ansent (kounye a)*

Other medical conditions (please list/explain):
*Lòt pwoblèm medikal (tanpri site/eksplike)*

_____
_____
_____
_____
_____
_____

Does your child have any **ALLERGIES** to the following?
*Èske pitit ou a fè nenpòt **ALÈJI** ak sa ki pral site la yo?*

❑NO KNOWN ALLERGIES
*PA AKOURAN DE ANKENN ALÈJI*

❑ Latex
*Latèks*

❑ Penicillin
*Penisilin*

❑ Medications:_____
*Medikaman*

❑Food/Other: _____
*Manje/lòt bagay*

Does your child take any medications? *Èske pitit ou a pran ankenn medikaman?*

❑ NO MEDICATIONS
*ANKENN MEDIKAMAN*

❑ YES, please list: _____
*WI, tanpri site yo*

Has your child ever been hospitalized or had surgeries? *Èske pitit ou a te janm entène lopital oswa li te fè operasyon?*

❑ NEVER BEEN HOSPITALIZED
*PA T JANM ENTÈNE LOPITAL*

❑ YES, please specify: _____
*WI, tanpri presize*

**Dental update**: Any changes since your last appointment?
*Mizajou dantè: Èske gen ankenn chanjman depi dènye randevou w la?*

❑ NO DENTAL CHANGES
*ANKENN CHANJMAN DANTÈ*

❑ YES, please explain: _____
*WI, tanpri eksplike*

**I attest that all information provided by me in this Recall Form is accurate and correct. I am aware that this information will be kept confidential and it is my responsibility to inform this office of any changes in my child's medical history. I authorize the dental staff to perform any necessary dental services that my child may require.**
*Mwen sètifye tout enfòmasyon mwen bay nan pakè pou retounen pasyan sa a egzat epi kòrèk selon tout konesans mwen. Mwen konnen yo pral kenbe enfòmasyon sa a konfidansyèl. Se responsablite pa m pou m enfòme ofis sa a si te gen ankenn chanjman nan antesedan medikal pitit mwen an. Mwen otorize pèsonèl dantè a pou l fè tout sèvis dantè ki nesesè pitit mwen an bezwen*

Name/*Non*: _____

Signature/*Siyati*:_____ Date/*Dat*: _____