Recall Patient Registration Form

Today's Date: ____________ Patient (Child's) Name: ____ Date of Birth: _____________

Reason for Visit: ❑ Recall ❑ Other _____________ Your Name: ____

Date of Birth: ________________________ **Your relationship to patient**: ____

Street Address: ____ City: _____________________State:_____ Zip: _____________

Home Phone:________________________ Cell Phone: _________________________ Work Phone: ________________________

Email:____ Driver's License #:______________________________________

Preferred contact method? (circle as applicable) E-mail Text Home Phone Cell Phone Work Phone

Patient Medical and Dental History

Does your child have a history of **ANY** of the following medical conditions below? Please check **ALL** that apply.

❑ **NONE OF THE BELOW APPLY**

- ❑ Heart Disease
- ❑ Cerebral Palsy
- ❑ Organ Transplant
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Seizures/Epilepsy
- ❑ Sickle Cell Disease
- ❑ Hepatitis Type A/B/C
- ❑ Rheumatic Fever
- ❑ Cystic Fibrosis
- ❑ Endocarditis
- ❑ Liver/Kidney Disease
- ❑ Diabetes (Type I or II)
- ❑ Sleep Apnea
- ❑ Abnormal Bleeding/ Hemophilia/Thalassemia
- ❑ History of Cardiac Surgery
- ❑ History of Blood Transfusions/Dialysis
- ❑ Bone Marrow Transplant
- ❑ History of Cancer/Tumors

The conditions in this box may require medical consultation and antibiotic prophylaxis.

- ❑ Innocent Heart Murmur
- ❑ Spina Bifida
- ❑ Asthma
- ❑ Visual/Auditory impaired
- ❑ GI Disorders/Reflux
- ❑ Speech Impediment
- ❑ ADHD
- ❑ Recurrent Ear Infections
- ❑ Autism
- ❑ Whooping Cough
- ❑ Down's Syndrome
- ❑ Eating Disorder
- ❑ Developmental Delay
- ❑ Dizziness/Fainting
- ❑ Psychiatric Illness
- ❑ Genetic Disorder
- ❑ Drug/Alcohol/Tobacco use
- ❑ Pregnant (Currently)

Other medical conditions (please list/explain):

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Does your child have any **ALLERGIES** to the following? ❑ NO KNOWN ALLERGIES ❑ Latex ❑ Penicillin

❑ Medications:____ ❑ Food/Other: ____

Does your child take any medications?

❑ NO MEDICATIONS ❑ YES, please list: ____

Has your child ever been hospitalized or had surgeries?

❑ NEVER HOSPITALIZED ❑ YES, please specify: ____

Dental update: Any changes since your last appointment?

❑ NO DENTAL CHANGES ❑ YES, please explain: ____

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.

Signature: ____Date: ________________________

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