

**MINOR/CHILD
REGISTRATION**

(PLEASE PRINT)

DENNIS D. GEMAR, D.D.S.

9664 Quivira Rd.
Lenexa, KS 66215

Telephone: (913) 888-8333

Phone _____

PATIENT INFORMATION

Date _____

Name of Minor/Child _____
Last Name First Name Initial

Sex M F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone _____ <small>(if different from above)</small>	Home Phone _____ <small>(if different from above)</small>
Work Phone _____ <small>(if different from above)</small>	Work Phone _____ <small>(if different from above)</small>
Employer _____	Employer _____
Soc. Sec.# _____ Birthdate _____	Soc. Sec.# _____ Birthdate _____
Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____	Plan Name _____
Phone No. _____	Phone No. _____
Address _____	Address _____
Group# _____	Group# _____
Policy# _____	Policy# _____
Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's Medical Assistance Identification# _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service _____

	YES	NO		YES	NO
Has child complained about dental problems? _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day? _____	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc? _____				<input type="checkbox"/>	<input type="checkbox"/>

(OVER)

MEDICAL HISTORY

Minor/Child's Physician _____	City/State _____	Phone _____
Date of last physical examination _____	Results _____	
Is Minor/Child under care of physician now? _____	YES NO <input type="checkbox"/> <input type="checkbox"/>	Medications _____
Receiving any medication or drugs? _____	<input type="checkbox"/> <input type="checkbox"/>	_____
Ever been hospitalized? _____	<input type="checkbox"/> <input type="checkbox"/>	_____
Ever had surgery? _____	<input type="checkbox"/> <input type="checkbox"/>	Allergies _____
Is there excessive bleeding when cut? _____	<input type="checkbox"/> <input type="checkbox"/>	_____
HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF SO PLEASE CHECK (✓)		
<input type="checkbox"/> A.I.D.S./H.I.V.	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Fainting
<input type="checkbox"/> Asthma	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian

Date

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian

Date

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____