Phillip D. Prater, D.D.S.
FAMILY DENTISTRY
434-292-3695
929 South Main Street • P.O. Box 458
Blackstone Va 23824

Children's Registration Form

Patient's name:_____ Date of Birth:_____

Sex: _____ Name of legal guardian:_____

Home phone: _____ Mobile phone: _____

Email address: _____

Mailing address: _____ City _____State _____ Zip _____

Whom may we thank for referring you to our office? _____

Insurance Information:

- o Not covered by dental insurance

Member ID#:_____Dental Insurance Company: _____

Group Number: _____ Claims Address: _____

Covered by secondary insurance? Yes or No (circle one)

Subscriber's Name: _____

Subscriber's dental insurance company: _____ Group number: _____

Subscriber's birthday: _____ SS# or Member ID#: _____

Please complete the medical health history on the back of this form

Health Information

Date of Last Dental Visit:

Have you ever had any of the following?

1. Yes No ADD/ADHD
2. Yes No Allergies (if yes please specify) _____
3. Yes No Anxiety/Panic
4. Yes No Asthma
5. Yes No Autistic
6. Yes No Blood Disease
7. Yes No Cancer
8. Yes No Diabetes
9. Yes No Dizziness
10. Yes No Down Syndrome
11. Yes No Epilepsy
12. Yes No Excessive Bleeding
13. Yes No Fainting
14. Yes No Growths
15. Yes No Hay Fever
16. Yes No Heart Murmur
17. Yes No Hepatitis
18. Yes No High Blood Pressure
19. Yes No Jaundice
20. Yes No Kidney Disease
21. Yes No Liver Disease
22. Yes No Mental Disorders
23. Yes No Nervous Disorders
24. Yes No Radiation Treatment
25. Yes No Respiratory Problems
26. Yes No Stomach Problems
27. Yes No Stroke
28. Yes No Tuberculosis
29. Yes No Tumors
30. Yes No Ulcers
31. Yes No Developmentally Delayed

Name of Child's Physician_____ **Office Number** _____

Has the patient experienced any unfavorable reaction from any previous dental or medical care? If yes, please explain. _____

Does the patient live in an area where water supply is fluoridated? Yes No

PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS TAKING (INCLUDING OVER-THE-COUNTER MEDICATIONS):_____

PLEASE LIST ALL MEDICATIONS THAT THE PATIENT IS ALLERGIC TO:

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes regarding the patient's health or medications.

Parent/Guardian Signature: _____

Date: _____

To Be Completed By Office Staff:

Medical History Reviewed

Signature/Date: _____ _____

_____ _____

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Acknowledgement of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I acknowledge that I have been informed of Prater Family Dentistry's privacy practices. I am aware that a copy of this office's notice of privacy practices is available for my review.

My or my minor child's dental history and account can be discussed with the following person(s), until revoked by me in writing.

(Name) (Relation) (Phone)

_____

_____

_____

_____ _____ _____

Printed Name **Signature** **Date**

_____

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (please specify)**