



CHILDREN'S NEW PATIENT REGISTRATION FORM



Today's Date: _____ / _____ / _____ Name: _____
 Male Female Child's Date of Birth: _____ / _____ / _____
 Address: _____ City: _____ State: _____ Zip: _____
 Parent's Home P#: _____ Parent's Work Ph#: _____ Parent's Cell #: _____
 Parent's E mail: _____ FT / PT Patient- College Student
 (College/Univ-Name/Town/State of College): _____
Who referred you? Refer a Friend _____ Yellow Book DEX
 Phone Book Internet ..GOOGLE or other? _____
 Emergency Contact: Name: _____ Relationship: _____
 Who accompanied minor patient today? _____

PARENTAL/GUARDIAN INFORMATION:

Father's/Guardian's Name: _____ Address: (if different from patient's) _____ _____ H # _____ W# _____ cell # _____ SS#: _____ / _____ / _____, D.O.B. _____ / _____ / _____ Employer: _____ DENTAL INSURANCE: Y/N? primary? Y/N? Ins Company Name: _____ Gr#: _____	Mother's/Guardian's Name: _____ Address: (if different from patient's) _____ _____ H # _____ W # _____ Cell# _____ SS#: _____ / _____ / _____, D.O.B. _____ / _____ / _____ Employer: _____ DENTAL INSURANCE: Y/N? primary Y/N? Insurance Company Name: _____ Gr#: _____
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CONSENT FOR TREATMENT:

I being the parent or guardian of _____ do hereby request and authorize the
Name of Minor Child
 the dental staff to perform necessary dental services for my child, including, but not limited to x rays, and
 administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual
 appointment when the treatment is rendered. I certify that the information that I have provided on this form is
 complete and accurate to the best of my knowledge. I understand that providing accurate information regarding my
 health allows Brink Street Dental, Ltd. to treat me effectively and safely. I understand that I am financially responsible
 for all charges whether they are covered by insurance or not. I understand that I will be consulted as
 recommended treatment and alternatives before treatment is provided.

_____ / _____ / _____ **X**

Date: _____ Signature of Insured/Guardian:

ASSIGNMENT OF BENEFITS TO INSURANCE:

I, the undersigned, have dental insurance coverage and request assignment of benefits to Dr. David Niles of Brink
 Street Dental, Ltd. I understand that the information given will be held in strict confidence. I hereby authorize the
 doctor to release all information necessary to secure the payment of benefits unless revoked. I authorize the signature
 on all insurance submission whether manual or electronic:

_____ / _____ / _____ **X**

Date: _____ Signature of Insured:



NEW PATIENT MEDICAL FORM



Patient Name: _____

Health Information

Do you have, or have you had any of the following? Please check those that apply

For both adults/child:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Smoker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis circle: (A,B,C)	# Cigarettes/Day _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	# Yrs Smoked _____
<input type="checkbox"/> Artificial joints or implants?	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stomach Problems
Location of implant: _____	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumors
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental or Nervous Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Excessive Bleeding	Due Date: ____/____/____	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Fainting	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Drug Allergies: _____
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Rheumatic Fever	_____
	<input type="checkbox"/> Rheumatism	_____

For our children patients (Check those that apply):

- Measles yes/no, chicken pox yes/no,
- Mononucleosis yes/no, ADD/ADHD yes/no,
- Mumps yes/no, Sinus Problems yes/no,
- Autism yes/no, Artificial limb/metal implant yes/no

Current Medications: _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No If yes, please explain: _____



NEW PATIENT DENTAL FORM



Dental Information

Do you have, or have you had any of the following? Please check all those that apply

For both adults and children:

<input type="checkbox"/> Do you have sensitive gums?	<input type="checkbox"/> Allergy to Antibiotics? (i.e. penicillin)
<input type="checkbox"/> Do you have headaches?	<input type="checkbox"/> Allergy to Iodine?
<input type="checkbox"/> Are your teeth sensitive to hot/cold?	<input type="checkbox"/> Allergies to Sulfa drugs?
<input type="checkbox"/> Have you had difficult extractions in the past?	<input type="checkbox"/> Allergic to Sedatives?
<input type="checkbox"/> Do you grind your teeth?	<input type="checkbox"/> Allergic to Barbiturates?
<input type="checkbox"/> Have you had a previous negative dental experience?	<input type="checkbox"/> Allergic to metals (i.e. nickel, mercury?)
<input type="checkbox"/> Do you floss regularly?	<input type="checkbox"/> Allergic to Aspirin?
<input type="checkbox"/> Have you a negative reaction to Novocain?	<input type="checkbox"/> Allergic to Latex Rubber?

For our children patients:

Does your child have a habit of: Lip Sucking/Biting?

Does your child have a habit of Nail Biting?

Does your child have a habit of Thumb/Finger Sucking?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X

Signature of patient, parent or guardian

X

Date: