Bryan Byrnside, DMD

40 W. Caldwell St. Suite 202
Mount Juliet, TN 37122
(615) 758-7511

Date: ____/____/____

Patient Registration & Health History

Please take a few minutes to fill out this form as completely as possible.
If you have any questions, we will be happy to assist you.

Patient Information

Child's Full Name____ Preferred name_________________________

Social Security #____________________________ Birth Date_____________ Sex ___M___F

Child Lives with ___Both Parents ___ Mother ___ Father ___ Other: __________________

Siblings (Names and Ages)____

Childs Favorite Sport/Activity/Hobby_______________________________________

School Name and Grade____

Emergency Contact________________________________ Phone________________________________

Whom may we thank for referring you to our practice? ____

What is the reason for your child's dental visit? ____

Parent/Legal Guardian Information

__Mother __Father __Stepmother __Stepfather __Grandmother __Grandfather __Other____________________

Full Name (First) ____________________ (Middle) ____________ (Last) ______________________

Address ____City ___________________ State ___ Zip __________

Home Phone _____________________ Cell Phone ____________________ Work Phone __________________

Email Address ___________________________ Birth Date ____________________ SS#_______________________

Place of Employment _____________________________________ Occupation ________________________

Parent/Legal Guardian Information (if applicable)

__Mother __Father __Stepmother __Stepfather __Grandmother __Grandfather __Other____________________

Full Name (First) ____________________ (Middle) ____________ (Last) ______________________

Address ____City ___________________ State ___ Zip __________

Home Phone _____________________ Cell Phone ____________________ Work Phone __________________

Email Address ___________________________ Birth Date _____________________ SS#______________________

Place of Employment _____________________________________ Occupation ________________________

Primary Insurance Information

Subscriber ___________________________ Date of Birth: _____________________ Subscriber SS#: ________________

Employer Name & Address____

Insurance Carrier __________________ Subscriber ID Number __________________Group Number _________________

Secondary Insurance Information (if applicable)

Subscriber ___________________________ Date of Birth: _____________________ Subscriber SS#: ________________

Employer Name & Address____

Insurance Carrier __________________ Subscriber ID Number __________________Group Number _________________

Medical History

Pediatrician _____________________________ City ______________________ Phone:___________________

Date and reason for last visit ____

Were there any problems at birth ? ☐Yes ☐No Explain:____

Was your child ☐breast fed ☐bottle fed ? At what age was it stopped? __________________________________

Previous hospitalizations or surgeries ☐Yes ☐No If yes, explain____

Any handicaps/disabilities ☐Yes ☐No If yes, explain____

Does your child require pre-medication before dental treatment? ☐Yes ☐No Explain:___________________________

Has your child ever been diagnosed with any of the following?

ADD/ADHD	☐Yes	☐No	Drug Abuse	☐Yes	☐No	Mumps	☐Yes	☐No
AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Asthma	☐Yes	☐No	Headaches	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Autism	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sinus Problems	☐Yes	☐No
Bladder Issues	☐Yes	☐No	Heart Surgery	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Bleeding Issues	☐Yes	☐No	Hepatitis	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Cancers/Tumors	☐Yes	☐No	Hemophilia	☐Yes	☐No	Other: __________________________		
Cerebral Palsy	☐Yes	☐No	Kidney/Liver Disease	☐Yes	☐No	________________________________		
Hearing Loss	☐Yes	☐No	Learning Disabilities	☐Yes	☐No	________________________________		
Chicken Pox	☐Yes	☐No	Measles	☐Yes	☐No	________________________________		
Diabetes	☐Yes	☐No	Mental Problems	☐Yes	☐No	________________________________		

Girls, are you pregnant? ☐Yes ☐No

Medications

Please list any medications your child is currently taking, dosage, and reason for use? _____________________________

____

____

Allergies ☐None ☐Penicillin/Amoxicillin ☐Latex ☐Aspirin ☐Sulfa ☐Local anesthetic

Other (please list)____

Dental History

Purpose of this appointment_____________________________ Problems/Concerns_______________________________

Date of Last visit ___________________________ Previous Dentist _______________________________

Has your child ever had dental x-rays? ☐Yes ☐No Date__________________________

Do you think your child will react well to dental treatment? ☐Yes ☐No Explain:_____________________________

Has your child complained of any dental pain? ☐Yes ☐No Explain:____

Has your child had any negative dental experiences? ☐Yes ☐No Explain:___________________________________

Has your child had any injuries to the mouth/teeth/head? ☐Yes ☐No Explain:________________________________

Does your child suck a fingher/thumb/pacifier? ☐Yes ☐No Explain:____

Does your child nurse/use a bottle/sippy cup? ☐Yes ☐No Explain:____

Does your child have any unusual speech habits? ☐Yes ☐No Explain:___________________________________

Do you assist your child with tooth brushing? ☐Yes ☐No How many times per day does your child brush? ____
Does your child use a manual or an electric brush? ________________________

Do you assist your child with flossing? ☐Yes ☐No How many times per week does your child floss? ____

Does your child eat between meals? ☐Yes ☐No Does your child drink between meals (except water)? ☐Yes ☐No
What is your child's favorite food? ___________________ What is your child's favorite snack? ______________________

Please mark the box if your child is having problems with any of the following:

☐Cavities ☐Toothache ☐Tooth Sensitivity ☐Biting ☐Gum Infection ☐Color of Teeth ☐Grinding

☐Jaw Popping/Clicking ☐Persistent bad breath ☐Other____

Fluoride History

Is your home water supply fluoridated? ☐Yes ☐No

Does your child use a fluoride toothpaste? ☐Yes ☐No

Does your child use a fluoride supplement? ☐Yes ☐No If yes, dose and frequency________________________

Do you give your child any other forms of fluoride? ☐Yes ☐No If yes, type__________________________

Is there any other information that we need to be aware of regarding your child that has not been covered in this form?

☐Yes ☐No Explain: ____

I request and authorize Dr. Byrnside and his staff to examine, photograph, clean and provide my child with comprehensive dental treatment. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Byrnside will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments. I agree to remain on-site during my child's dental appointment. I understand that I will be responsible for any charges incurred on this child for dental treatment. I certify that the information given is correct to the best of my knowledge. All information 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, insurance, and contact information.

Signature: ____________________________________ Date: _____________

Office Use Only

Reviewed by: _____________

Date: __________________