Bellevue Dental Arts
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BELLEVUE DENTAL ARTS
Ryan Chiang, DDS | Norman Chiang, DDS

Children under 16 - Patient Registration Form

Tell us about your child

Child's Name: _____ Preferred Name: _____ Male O Female O
Child's Age: _____ Child's D.O.B.:_____ School:_____ Grade:_____
Child's Home Address:_____
Child's Home Phone:_____ S.S.N._____
Siblings that we treat:_____

Who is accompanying the child today?

Name:_____ Relation:_____ Do you have legal custody of the child? Yes O No O
In case of emergency, contact (name & phone #)_____
Whom may we thank for this referral:_____

Parent/guardian information

Mother/Guardian
Name:_____ D.O.B._____
Address:_____
_____
Employer:_____ For how long?_____
Occupation:_____
S.S.N._____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
E-mail Address:_____
Marital Status:_____

Father/Guardian
Name:_____ D.O.B._____
Address:_____
_____
Employer:_____ For how long?_____
Occupation:_____
S.S.N._____
Home Phone:_____
Work Phone:_____
Mobile Phone:_____
E-mail Address:_____
Marital Status:_____

Who is the responsible party for this account? _____

Dental Insurance Information

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone:_____ Group#or Plan, Local or Policy #:_____
Insured's Name:_____ Relationship to child:_____
Insured's D.O.B._____S.S.N:_____ Insured's Employer:_____

Dental History

Has your child ever suffered from any of the following dental related problems?

Yes	No		Yes	No	
O	O	Speech Problems	O	O	Popping or Soreness of the Jaws (Right, Left or Both)
O	O	Grinding or Bruxing Habit	O	O	Previous Dental Infection or Abscess
O	O	Stained or Discolored Teeth	O	O	Pain from Teeth Where? _____
O	O	Cold Sores or Fever Blisters	O	O	Past Injury or Trauma to Teeth, Mouth, Lips or Face

Has your child been prescribed fluoride supplements/use fluoridated toothpaste? O Yes O No If yes, please explain. _____
Does your child brush their teeth two times a day? O Yes O No If so, do you assist? O Yes O No
Does your child suck a thumb, finger, pacifier or blanket? O Yes O No
How would you predict your child's behavior to be today? O Cooperative O Nervous O Defiant O Don't Know
Has your child ever been treated by a dentist? O Yes O No A pediatric dentist? O Yes O No If so, who?_____
Previous dentist's phone number:_____
When was your child's last dental visit? _____ Were radiographs taken at this visit? O Yes O No O Don't Know

What are your primary concerns regarding your child's oral health?

_____
_____

Medical History

Has your child ever had any of the following conditions?

Yes No

- O O Sickle Cell Anemia or Trait (when? _____)
- O O Bleeding Disorder or Hemophilia _____
- O O Tonsillectomy and/or Adnoidectomy (when? _____)
- O O Bruises or Bleeds Easily
- O O Anemia or Blood Disorders
- O O Heart Murmur (Innocent or Pathological)
- O O Immunologic Disorder, HIV, AIDS or ARC
- O O Heart Condition_____
- O O Hypertension or Hypotension
- O O Rheumatic Fever/Scarlet Fever
- O O Cystic Fibrosis
- O O Asthma or Lung Problems (Inhaler, Nebulizer)
- O O Thyroid Disorder
- O O Cancer, Lymphoma or Leukemia _____
- O O Seizure Disorder, Epilepsy (Last Episode _____)
- O O Blood Transfusions
- O O Learning Disability (Mild, Moderate, Severe)
- O O Autistic (Mild, Moderate, Severe)
- O O Diagnosed with ADD, ADHD or Hyperactivity
- O O Delayed Development, MR (Approx age child functions____)
- O O Liver Disease or Transplantation_____

Yes No

- O O Measles, Mumps, or Chicken Pox
- O O Malignant hyperthermia
- O O Skin Disorder or Eczema _____
- O O Hepatitis (Type ____)
- O O Chronic Ear Infections / Otitis Media
- O O Tuberculosis or Positive Test Result (when? _____)
- O O Stomach or GI Disorder _____
- O O Is parent pregnant?
- O O Snoring or Sleep Apnea?)
- O O Seasonal Allergies, Hay Fever, etc.
- O O Diabetes Mellitus (NIDDM or IDDM_____ x day)
- O O Febrile Seizure, Fainting Spells
- O O Frequent Headaches
- O O Cleft Lip and/or Palate (Bilateral, Unilateral) (Right, Left)
- O O Congenital Birth Defects/Syndrome _____
- O O Cerebral Palsy, Muscular Dystrophy
- O O Kidney Disease or Transplantation
- O O Handicaps or Disabilities _____
- O O Hospital Stays or Significant Injuries _____
- O O Is child's immunization record current?

Comments (Office Use Only):

Please list all medications patient is currently taking _____

Yes No

- O O Is your child allergic or ever had an adverse reaction to a medication? If so, which?_____
- O O Does your child have an allergy to latex, foods or dyes? If so, which?_____

Other Medical Conditions Not Noted Above: _____

Please list the names & phone numbers of any physicians that are currently treating your child.

Type of Physician:_____ Doctor's Name_____ Office Phone Number_____
Type of Physician:_____ Doctor's Name_____ Office Phone Number_____
Type of Physician:_____ Doctor's Name_____ Office Phone Number_____

Consent and authorization

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Since my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental service can be started. I grant Dr. Ryan Chiang or Dr. Norman Chiang and staff specific consent to do an oral exam, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions, if deemed necessary. I understand I will be consulted before any treatment is rendered.

I authorize the insurance company indicated on this form to pay Dr. Chiang all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Chiang to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Parent/Guardian Signature Date