Date:_____

Patrick C. Creevan, D.D.S., Inc.
Pediatric Dentistry
1964 Fourth Street
Livermore, CA 94550

Primary Phone:_____

New Patient Registration

Child's Name:_____ Nickname:_____ Sex: M F
First Middle Last

Birthday: _____ /_____ /_____ Is child adopted? Y N Does child know they are adopted? Y N
Month Day Year

Child's school:_____ Interests/Hobbies/Clubs:_____
Name & Age of brother(s):_____
Name & Age of sister(s):_____ Name of Pet(s):_____
Who may we thank for referring you to us?_____

Dental History:

Is this your child's first visit to a dentist? Y N If no, previous dentist_____Phone: ( )_____-_____
Date of last visit:_____/_____ Were x-rays taken? Y N How was his/her experience?_____
Purpose of today's visit:_____ Concerns:_____
Has your child had any injuries to teeth, mouth or head? Y N If yes, please describe:_____
Does your child have any special needs? _____

Any history of: Thumb/finger sucking Pacifier Nursing Bottle feeding Nail biting Teeth grinding Snoring

Does your child brush their teeth?	Y	N	How often?_____
Does your child brush with adult supervision?	Y	N	
Does your child floss?	Y	N	How often?_____
Does your child take a fluoride supplement? (ie: pills, drops, vitamins)	Y	N	
Is your water fluoridated?	Y	N	
Does your child use a fluoride toothpaste?	Y	N	

How can we make this a positive experience for your child?_____

Medical History:

Child's pediatrician:_____ Phone: ( )_____-_____
Is your child under the care of a physician now? Y N If yes, reason:_____
Date of last physical: _____/_____ Immunization(s) up to date? Y N
Is you child currently taking any medications, including over the counter? Y N Please list:_____
Is your child allergic to any food or medication? Y N Please list:_____
Is your child allergic to latex? Y N _____
Any history of hospitalization and/or surgery Y N
If yes, please list with dates:_____

Has your child had a history or difficulty with any of the following? **Please Mark Y or N for all conditions listed below**

A.I.D.S./H.I.V.	Y	N	Bruising	Y	N	Hard of Hearing/Deaf	Y	N
ADHD/ADD	Y	N	Cancer	Y	N	Heart Murmur	Y	N
Anemia	Y	N	Cardiac Disease/Heart	Y	N	Hepatitis	Y	N
Allergies (Seasonal)	Y	N	Cerebral Palsy	Y	N	Immune Disorder	Y	N
Anxiety	Y	N	Chemo/Radiation Therapy	Y	N	Kidney Issues	Y	N
Anaphylactic Allergy Response	Y	N	Cystic Fibrosis	Y	N	Liver Issues	Y	N
			Delayed Development	Y	N	Muscular Disorder	Y	N
Arthritis/Joints	Y	N	Depression	Y	N	Premature Birth	Y	N
Asthma	Y	N	Diabetes	Y	N	Rheumatic Fever	Y	N
Autism	Y	N	Down's Syndrome	Y	N	Speech Disorder	Y	N
Bladder	Y	N	Earaches/Infections	Y	N	Sinusitis	Y	N
Bleeding Disorder	Y	N	Eating Disorder	Y	N	TMJ Problems	Y	N
Bone Disorder	Y	N	Emotional/School Problems	Y	N	Tuberculosis	Y	N
Brain Injury	Y	N	Epilepsy/Seizures	Y	N	Visually Impaired	Y	N

Other:_____

Parent/Legal Guardian Information:

Father:_____
Address:_____
_____
Home Phone: ( )_____-_____
Work Phone: ( )_____-_____
Cell Phone: ( )_____-_____
E-mail address:_____
SSN: _____-_____-_____Birthday: _____/_____/_____
Parents are: Married_____ Divorced_____ Single_____ Widowed_____ Partners_____ Other_____
Child lives with:_____Name of person financially responsible for treatment:_____

Employer: _____
Occupation:_____
Dental insurance provided by this employer? Y____ N____
Insurance Company Name:_____
Insurance Company Phone: ( )_____-_____
Group #:_____Union Local #_____
Member ID:_____

Additional Primary Caregiver (Optional):
Name:_____
Relationship to child:_____
Phone: ( ) _____-_____

Mother:_____
Address:_____
_____
Home Phone: ( )_____-_____
Work Phone: ( )_____-_____
Cell Phone: ( )_____-_____
E-mail address:_____
SSN: _____-_____-_____Birthday: _____/_____/_____

Employer: _____
Occupation:_____
Insurance provided through this employer? Y_____ N_____
Insurance Company Name:_____
Insurance Company Phone: ( )_____-_____
Group #:_____Union Local #_____
Member ID:_____

Emergency Contact:
Name:_____
Relationship to child:_____
Phone: ( ) _____-_____

Multiple Patient Family: complete guardian & insurance info provided on sibling registration form (name):_____
Permission for the office of Dr. Patrick Creevan to use e-mail & cell phone as a means of communication: Initial _____

Authorization and Acknowledgement:

The persmission of a parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in Dr. Patrick C. Creevan's professional judgement to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status or contact information. I have also received a copy of "The Facts About Fillings" as required by law.

SIGNATURE:_____ **Print Name:**_____
Relationship to Patient:_____ **Date:** _____/_____/_____

Financial Agreement:

For patients with dental insurance:I hereby authorize the dentist to release any information including diagnosis and records to the third party payor and/or other health care practitioners. I authorize and request my insurace to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization, I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services; and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information, including the SSN of the party completing these forms. You are required to pay your portion on the day of treatment; without a SSN payment is required in full; we will provide you with the competed claim to mail, directing any insurance reimbursements to the policyholder.
For patients without insurance: Payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services.
and where appropriate, a credit bureau report may be obtained.
You may opt to receive a statement of your account balance, payable within 30 days of services rendered, however, you must provide a social security number. This policy may be subject to change depending on timely account payment.
A $75 missed appointment fee may be charged to your account for appointments that are missed or cancelled with less than 24 hours notice.

SIGNATURE:_____ **Print Name:**_____
Relationship to Patient:_____ **Date:** _____/_____/_____

For Office Use Only:
____Medical/Dental history reviewed verbally with parent/guardian for above patient
Signature_____ Date:_____/_____/_____