Orange County Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

Patient Registration

PATIENT INFORMATION

First Name		MI		Last Name	
Nickname		Birth Date		Gender	❑ Male ❑ Female

Patient lives with (check all that apply)

❑ Both Parents ❑ Mother ❑ Father ❑ Step-parent ❑ Shared Custody ❑ Other _____

List child's hobbies, sports, interests, pets, etc.	
Names & ages of other children in your family	

Who may we thank for referring you to our office?

❑ Current Patient ❑ Referral Doctor ❑ Internet ❑ Insurance ❑ Other _____

Referral Name	

GUARDIAN'S INFORMATION #1

❑ Self ❑ Mother / Father ❑ Stepmother / Stepfather ❑ Guardian

First Name		Last Name		Birth Date	
Social Security #		Email Address			
Address		City		State	ZIP Code
Home Phone		Work Phone	Ext.	Cell Phone	
Employer					

GUARDIAN'S INFORMATION #2

❑ Mother / Father ❑ Stepmother / Stepfather ❑ Guardian

First Name		Last Name		Birth Date	
Social Security #		Email Address			
Address		City		State	ZIP Code
Home Phone		Work Phone	Ext.	Cell Phone	
Employer					

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First		Last		
Relation		Gender	❑ Male ❑ Female		
S.S. #		Birth Date			
Address					
City		State		ZIP Code	
Telephone					
Primary Policy Holder Employer					
Business Address					
City		State		ZIP Code	
Business Telephone					
Insurance Co. Name					
Address					
City		State		ZIP Code	
Telephone					
Policy I.D. #					
Group #		Plan Name			

SECONDARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First		Last		
Relation		Gender	❑ Male ❑ Female		
S.S. #		Birth Date			
Address					
City		State		ZIP Code	
Telephone					
Primary Policy Holder Employer					
Business Address					
City		State		ZIP Code	
Business Telephone					
Insurance Co. Name					
Address					
City		State		ZIP Code	
Telephone					
Policy I.D. #					
Group #		Plan Name			

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HEALTH HISTORY

Child's Physician Name	

Are your child's immunizations up to date?	❑ Yes	❑ No
Does your child have a heart condition?	❑ Yes	❑ No
Has your child undergone any surgeries or hospitalizations?	❑ Yes	❑ No
Have you been told that your child should have antibiotics before dental visits?	❑ Yes	❑ No
If applicable, is the patient taking birth control medication?	❑ Yes	❑ No
Is the patient pregnant?	❑ Yes	❑ No

If you answered YES to any of the questions above, please explain in detail:

Does your child have, or have had, any of the following?

	YES	NO		YES	NO		YES	NO
Abnormal Bleeding			Diabetes			Radiation Treatment		
ADD/ ADHD			Developmental Delay			Respiratory Problems		
Allergies, seasonal			Eating Disorders			Rheumatic Fever		
Anemia			Epilepsy			Seizures		
Arthritis			Head Injuries			Sensory Processing Disorder		
Artificial Joints			Hearing Impairment			Sickle Cell Disease		
Artificial Heart Valve			Heart Murmur, Heart Defect or Disease			Skin Conditions		
Asthma			Hepatitis (any type)			Speech Delay/ Therapy		
Autism			High Blood Pressure			Stomach/Intestinal Problems		
Behavioral Problems			HIV/ AIDS			Sleep Apnea		
Blood Disease			Jaw Joint Pain			Thyroid Problems		
Cancer			Kidney Disease			Tonsils/Adenoids Surgery		
Cerebral Palsy			Liver Disease			Tuberculosis		
Cleft Lip / Palate			Premature Birth			Tumors/ Growths		
Covid-19 Virus			Psychiatric Care			Upper Respiratory Infection		

Is there any disease, condition or problem that you think our office should know about that is not listed above?	❑ Yes	❑ No

Please explain any conditions selected above along with any other condition not listed.

MEDICATIONS

Please list all medications, over the counter and herbal supplements that your child is taking (include medication, dosage & frequency, if possible)

ALLERGIES

Is your child allergic to, or has had a reaction to, any of the following?

	YES	NO		YES	NO		YES	NO
Dental Anesthetics			Sulfa Drugs			Latex		
Jewelry			Codeine			Penicillin or Amoxicillin		
Metals			Erythromycin			Tetracycline		

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Please list any allergy/reaction not listed above.			

DENTAL HISTORY

Is this your child's first dental visit?		❑ Yes	❑ No
If not, how long has it been since his/her last dental visit?			
Previous dentist		**Date of last x-rays**	
Has your child experienced any injuries or trauma to his/her teeth, face or mouth?		❑ Yes	❑ No
If so, when and what happened			
Do you have any concerns about your child's dental health?		❑ Yes	❑ No
If so, please explain			
Is your child currently experiencing any pain or discomfort?		❑ Yes	❑ No
If so, describe in detail			
Does your child have any past unhappy dental experiences?		❑ Yes	❑ No

Does your child currently (check all that apply)

❑ Use a pacifier ❑ Use a sippy cup ❑ Use a bottle ❑ Breastfeed

❑ Suck his/her thumbs or fingers ❑ Tongue-thrust ❑ Have speech problems

Does your child or any family member have a history of difficulties with anesthesia?		❑ Yes	❑ No

ADDITIONAL NOTES/ COMMENTS

Permission for Treatment of a Minor

I, the parent of guardian of the above minor patient, do hereby authorize and request the performance of dental services for this patient; and further, the performance of whatever procedures the judgment of the doctor may deem necessary. I also authorize the administration of anesthetics or analgesics and the taking of radiographs when deemed necessary by the doctor.

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian		**Date**	

IF PATIENT IS A MINOR

Form signed by		**Relationship to Patient**	