Welcome to the office of Dr. Gary Woodall, DDS, MAGD

Please supply the following information in order that we may better serve you

CHILD REGISTRATION

Patient Information

Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Phone: (____)_____ Date of Birth:_____ Sex: ___ Male ___Female

Guarantor Information

Who is responsible for the payment of this account? _____
Date of Birth: _____ Social Security Number: _____
Occupation:_____ Employed by: _____
How long with company? _____ Work Phone: (____)_____

Is this patient covered under dental insurance? ____Yes ____No
If yes, please present card at front desk.

Is this patient covered under secondary insurance? ____Yes ____No
If yes, name of secondary company _____

Mother's Name: _____ If listed as guarantor, stop here.
Occupation:_____ Employed by: _____
How long with company? _____ Work Phone: (____)_____
Date of Birth: _____ Cell Phone: (____)_____

Father's Name: _____ If listed as guarantor, stop here.
Occupation:_____ Employed by: _____
How long with company? _____ Work Phone: (____)_____
Date of Birth: _____ Cell Phone: (____)_____

In the event of an emergency, who should we notify? _____
Phone Number (____)_____

Are you the legal guardian of this child? ___Yes ___No
If no, please state name of legal guardian: _____

Who may we thank for referring you? _____

Comments:

Medical History

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions…

Are you under a physician's care now?	☐ Yes ☐ No	_____	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	_____	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	_____	
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	_____	
Do you take or have you taken Phen-Fen or Redux?	☐ Yes ☐ No	Do you use tobacco?	☐ Yes ☐ No
Are you on a special diet?	☐ Yes ☐ No	Do you use controlled substances?	☐ Yes ☐ No

Women: Are you ____ Pregnant/Trying to get pregnant? ____ Nursing? ____ Taking oral contraceptives?

Are you allergic to any of the following?

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics ___Other_____

Do you have or have you had any of the following?

☐ Aids/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medication	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of the Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

***Condition may require medication prior to dental treatment**

Have you ever had any serious illnesses not listed above? ____No ____Yes _____

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or guardian **Date**