Mark Gilbert
Family Dentist

662-895-0100
8947 College St.
Olive Branch, MS 38654

Patient (Child) Registration and Medical History

Date: ____________________

Patient: ____

First Name **Last Name** **Preferred Name**

Date of Birth: ________________________________ **Age:** _________ **Male/ Female**

Address: ____

City: ____ **State:** ______________ **Zip:** _________________

Home Phone: ________________________________**Cell:** _____________________________________

Mom's Number: _________________________ **Dad's Number:** _______________________________

Which option would you prefer to be reached by to confirm your child's dental appointment? (Please circle one) **Call Mom home or cell** **Call Dad home or cell** **Text Mom** **Text Dad**

Father's Name ____________________________________ **Father's Date of Birth:** _________________

Father's Address: ____

City: ____ **State:** ____________________ **Zip:** __________

Father Employed By: _____________________________________ __ **Phone**_____________________

Mother's Name: ____________________________________ **Mother's Date of Birth:** ______________

Mother's Address: ____

City: ____ **State:** ___________________ **Zip:** __________

Mother Employed By: _____________________________________ **Phone:** ____________________

Mother's SSN: _______- _______-_________ **Father's SSN:** _______-_______-________

Primary Dental Insurance: ____

Name of Insured: ____

Secondary Dental Insurance: ____

Name of Insured: ____

In Case of an Emergency: ____________________________________ **Phone:** _____________________

Whom may we thank for referring you? ____

Date of your last dental cleaning: ____

Are you having any dental problem? ____

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Medical History

Physician's Name ____

Phone Number: ____

Are You Under The Care of a Physician? __________**If so, for what condition:** _____________

Have You Ever Had Any of The Following? (Check or Circle the Boxes that apply To You)

_____ **Acid Reflux**
_____ **Arthritis**
_____ **Artificial Joints or Heart Valves**
_____ **Asthma**
_____ **Back Problems**
_____ **Blood Disease**
_____ **Blood Thinner**
_____ **Cancer**
_____**Diabetes**
_____**Drug/Alcohol Dependent**

_____ **Epilepsy**
_____ **Headaches/Migraine**
_____ **Heart Problems/Damage/ Heart Attack/ Murmur**
_____ **Hemophilia**
_____ **Hepatitis A, B or C**
_____ **High Blood Pressure**
_____ **HIV+ or AIDS**
_____ **Jaundice / Liver Disease**
_____ **Radiation Treatment**
______ **Respiratory Disease**

____ **Seizers**
_____ **Sinus**
_____ **Stroke**
_____ **Smoker**
_____ **Smokeless Tobacco**
_____ **Tuberculosis**
_____ **Ulcer**

Do You Have Any Drug/Medication Allergy?

_____**Aspirin** ____ **Ceclor** _____ **Codeine** _____ **Dental Anesthetic** ______ **Erythromycin**
_____ **Keflex** _____ **Latex** _____ **Penicillin** _____ **Sulfur**

Other: ____

Are you taking any medications? _________ **if so, please list on the following attached sheet.**

I understand that I'm responsible for all charges for a services provided. If insurance applies I understand that I'm responsible for any remaining unpaid balances. I also understand it is my full financial responsibility to pay all court cost, fees and/or any attorney fees if my account is turned over for collections. As service to our patients, we will file charges for services to the insurance companies. However, we do consider the patient responsible for the account. When payment of insurance claim is assigned to us that estimated portion of the fee which is payable by the patient is due at the time of service.

Date: ____________________ **Signature:** ____

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Acknowledgment of Privacy Notice

I, ____, have been informed about the copy of this Office Notice of the Privacy Practice stating that my dental information will not be given out to anyone without my permission.

Signature: ____ Date: ________________________

List of Medication

Medication Name	Dosage and Milligram	Reason
Example: Aspirin	**1 time day 81mg**	**stroke**