REGISTRATION

PATIENT'S NAME ______________________________ Today's Date __________ Patient's Date of Birth ____________
Last First Initial

PARENT'S NAME ______________________________
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED? ______________________________

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

RESIDENCE- STREET ______________________________

CITY __________________ STATE______ ZIP ________

BUSINESS ADDRESS ______________________________

TELEPHONE RES: ______________ BUS.________________

CELL: ______________

PARENT EMPLOYED BY ______________________________

PRESENT POSITION ______________ HOW LONG HELD _____

SPOUSE/OTHER PARENT NAME__________________________

SPOUSE EMPLOYED BY ______________________________

PRESENT POSITION ______________ HOW LONG HELD_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?______________

DRIVERS LICENSE NO. ______________________________

RESPONSIBLE PARTY'S SOCIAL SEC# _XXX-XX- ___ ___ ___ ___

PURPOSE OF VISIT ______________________________

OTHER FAMILY MEMBERS IN PRACTICE__________________

____

WHOM MAY WE THANK FOR THIS REFERRAL? ____________

____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY
(NOT LIVING IN SAME HOUSEHOLD)____________________

____

DENTAL INSURANCE 1ST COVERAGE

SUBSCRIBER'S NAME______________________________

SUBSCRIBER'S DATE OF BIRTH ______________________

SUBSCRIBER'S SS# ______________________________

SUBSCRIBER'S INSURANCE ID#______________________

EMPLOYER ____________________________# YRS_____

NAME OF INSURANCE CO. __________________________

INS. CO. BILLING ADDRESS________________________

INS. CO. PH# ______________________________

GROUP OR POLICY # ______________________________

UNION LOCAL OR GROUP NAME______________________

DENTAL INSURANCE 2ND COVERAGE

SUBSCRIBER'S NAME______________________________

SUBSCRIBER'S DATE OF BIRTH______________________

SUBSCRIBER'S SS#______________________________

SUBSCRIBER'S INSURANCE ID#______________________

*EMPLOYER__________________________#YRS______

NAME OF INSURANCE CO.__________________________

INS. CO. BILLING ADDRESS________________________

INS. CO. PH#______________________________

GROUP OR POLICY #______________________________

UNION LOCAL OR GROUP NAME______________________

RELEASE:

1. I acknowledge that the above information is accurate.
2. I understand that all fees not covered by insurance are due on the day of service.
3. I authorize my insurance company to pay directly to the dentist.
4. I understand the by signing below that I am responsible for charges for all consented treatment.

Responsible Party ______________________________ Date____________________

PRIVACY STATEMENT:

1. I give permission to the doctors and the staff to disseminate health information to other health care providers that are also involved with the patient's care.
2. I have received the practice privacy statement.

Legal Guardian ______________________________ Date ____________________

Medical and Dental History

Patient's Name____ Birthdate__________ Age______ Male Female

MEDICAL HISTORY

Physician_____________________________________

Yes No
( ) ( ) Is patient in good health?
( ) ( ) Is patient under a physicians care? For what?________________________________
( ) ( ) Does patient have any history of major illness? What?________________________________
( ) ( ) Has patient ever been hospitalized? For what?________________________________
( ) ( ) Is the patient receiving any medication/drugs presently?________________________________
( ) ( ) Does patient have any allergies or drug sensitivity? Kindly List________________________________
( ) ( ) Does patient have a tendency to colds( ), sore throat( ), ear infections( ), sinus congestion( ), breathing problems( )
( ) ( ) Have tonsils and/or adenoids been removed? What age?________________________________

Check any of the following conditions for which the patient has been treated:

( ) AIDS
( ) Arthritis
( ) Asthma
( ) Blood Problems
( ) Blood Disorders
( ) Cerebral Palsy
( ) Diabetes
( ) Epilepsy/Seizures
( ) Emotional Problems
( ) Endocrine Problems
( ) Fainting/Dizziness
( ) Heart Problems
( ) Hepatitis
( ) HIV Positive
( ) Liver/Kidney Disease
( ) Nutritional Problems
( ) Prolonged Bleeding
( ) Rheumatic Fever
( ) Speech, Hearing Problem
( ) Tonsillitis
( ) Tuberculosis

Any other significant medical, psychological, or disability problems? ___ Please describe. ________________________________
____

DENTAL HISTORY

Previous Dentist_________________________________

Yes No
( ) ( ) Has there been any injuries to the face, mouth or teeth?________________________________
( ) ( ) Has the patient ever sucked their thumb or fingers? Until what age? ________________________________
( ) ( ) Does the patient have any speech problems? ________________________________
( ) ( ) Is the patient a mouth breather? While awake? ________________________________
( ) ( ) Does the patient have noticeable problems in chewing or swallowing? ________________________________
( ) ( ) Any clicking, popping, or discomfort upon opening or closing their mouth? ________________________________
( ) ( ) Does the patient see a dentist regularly? Date last seen? ________________________________
( ) ( ) Has any previous dental treatment occurred? If yes, what? ________________________________
( ) ( ) Were there any problems with the previous dental treatment? If yes, what were they? ________________________________
( ) ( ) Is your drinking water fluoridated?
( ) ( ) Are supplemental fluorides (e.g. rinse, gel, tabs) used? Please describe ________________________________

How often are teeth brushed? ___________________________________ Flossed? ___________________ By whom?_______________

If there are any special concerns, please state in your own words.________________________________

I acknowledge that this information is correct and hereby authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services. I authorize the use of any radiographs, photographs, and records for the purpose of teaching other health care professionals.

_____________________________________ Signature of Legal Consent

__________ Date

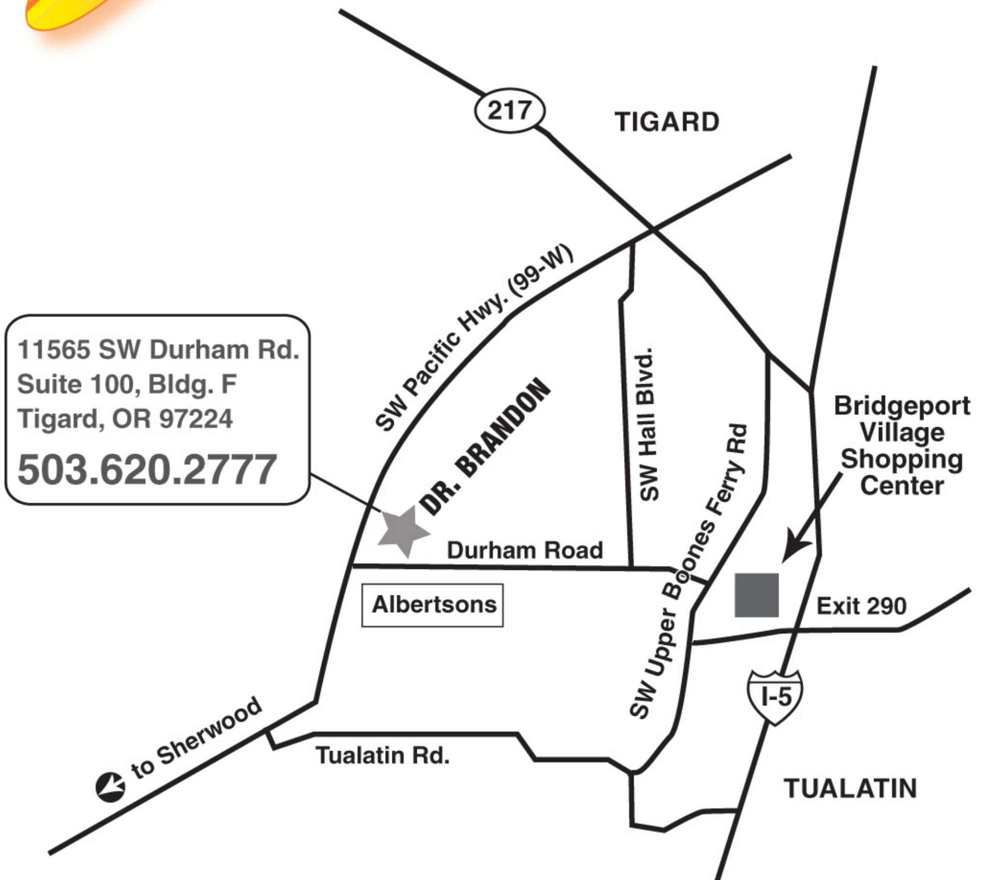
______________________________ Pediatric Dentist

__________ Date

Internal use only

DR. BRANDON
DENTISTRY FOR CHILDREN & TEENS
Brandon Schwindt, DMD, PC

ph. **503.620.2777**
fx. **503.620.2070**



Driving Directions From I-5:

TAKE EXIT 290 (Lower Boones Ferry Rd/Durham)

After you exit, go WEST on Boones Ferry Rd. towards Bridgeport Village Shopping Center.

Follow Boones Ferry Rd. STRAIGHT through the intersection. You will pass Crate and Barrel on your right and Jared's Jewelers on your left. When you come to a T in the road,

TURN RIGHT onto Upper Boones Ferry Road towards Tigard.

TURN LEFT onto Durham Road. You will cross railroad tracks and pass Tigard High School.

TURN RIGHT onto Summerfield Road.

TAKE AN IMMEDIATE LEFT into the parking lot; Our office is the 2nd building on the left.

DrBrandon.com