



RECALL PATIENT REGISTRATION FORM

PATIENT (CHILD'S) INFORMATION:

Patient's Name: _____ Date of Birth: _____
Reason for Today's Visit: Recall and/or other: _____

RESPONSIBLE PARTY (PARENT OR LEGAL GUARDIAN) INFORMATION:

Parent/Guardian Name: _____ Date of Birth: _____
Relationship to the patient? Biological Mother Biological Father Legal Guardian/Other: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Driver's License#: _____ S.S.# _____

MEDICAL HISTORY UPDATE

Does your child have a history of any of the following? (Please check all that apply): NONE OF THE BELOW APPLY

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver/Kidney Disease | <input type="checkbox"/> Drug/Alcohol Problems |
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Speech/Hearing Issues | <input type="checkbox"/> GI Reflux Disease | <input type="checkbox"/> Developmental Delays |
| <input type="checkbox"/> Hemophilia/Thalassemia | <input type="checkbox"/> Recurrent Ear Infections | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blood Transfusions/Dialysis | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Visual/hearing impaired | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ | | |

Does your child have any allergies to the following? NO KNOWN ALLERGIES
 Latex Penicillin Medications: _____
 Food/Other: _____

Does your child take any medications? NO MEDICATIONS TAKEN
 Yes, please list: _____

Has your child ever been hospitalized or had surgeries? NEVER BEEN HOSPITALIZED
 Yes, please specify: _____

DENTAL HISTORY UPDATE

The following has changed since our last dental appointment (if no changes, please check "no changes"):
 No changes | Changes: _____

Signature of Parent/Guardian: _____ Date: _____