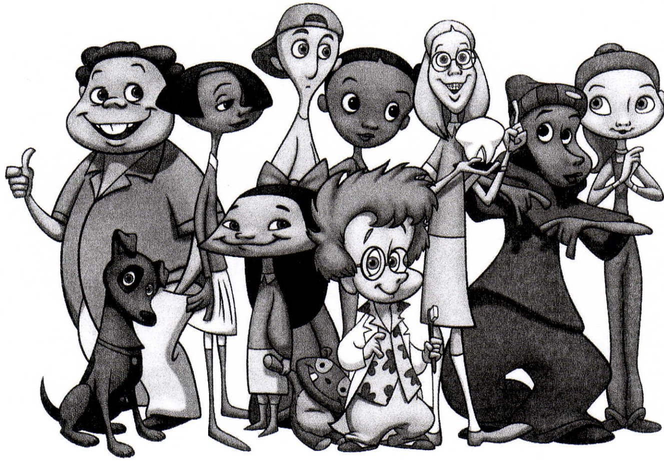

Welcome

Dr. Robyn Lesser, DMD
6415 Sheldon Road
Tampa, Florida 33615
(813) 880-0100

Patient Registration Form

1. Tell Us About Your Child

Child's Name ______________________________ Male ___ Female ___
Siblings ____________________________ DOB _______/_______/_______
Home # ______________________. Best # to Confirm Appts. __________________
Mailing Address ____

2. Who May We Thank for Referring You to Our Office?

____

3. Mother's Information

Name ___________________________
Circle: Mother Stepmother Guardian
Birthdate _____/_____/________
Work # _________________________
Cell # ___________________________
Social Security Number ___________
Drivers License # _________________
Occupation _______________________

4. Father's Information

Name _______________________
Circle: Father Stepfather Guardian
Birthdate: ____/_______/________
Work # ______________________
Cell # ________________________
Social Security Number __________
Drivers License # ______________
Occupation ____________________

5. Who is Accompanying the Child Today?

Name _____________________________
Relationship _________________________
Person Responsible for Account ________________________

6. Dental Insurance Information

Insurance Company Name ________________________ Phone number ____________
Insurance Company Claims Address __________________________________
Policy Owner/Subscriber Name_____________________ Group Number _______
Relationship to Patient ____
Social Security Number ______________ Subscriber Birthdate ____/_____/______
Policy Owner's Employer ____

7. Dental History

Is this your child's first visit to the dentist? Yes No

If not, how long since the last visit? ___________________________________

Previous Dentist's Name ____

Were any x-rays taken at the previous dentist? Yes No

Have there been any injuries to the teeth, face, or mouth? Yes No

If yes, please explain: ____

Why did you bring your child to the dentist today? _________________________

Does your child have any of the following habits? Please circle:

Lip Sucking/Biting Nail Biting Nursing/Bottle Habits Thumb/Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No If yes, please explain: ________________________

____

Is your child's water fluoridated? Yes No

Is your child taking fluoride supplements? Yes No

Has the child ever had pain or tenderness in the jaw or joint? (TMJ/TMD?) Yes No

Do you expect your child to be a cooperative patient? Yes No Explain ____________

Does your child need premedication with antibiotics before dental appts? Yes No

8. Health History: Does the child have any of the following conditions?

Y N Abnormal bleeding
Y N Allergies to drugs/latex products
Y N Any operation/hospital stays
Y N HIV/AIDS
Y N Asthma
Y N Cancer/tumor/leukemia
Y N Congenial birth defects
Y N Cleft/lip/palate
Y N Hepatitis
Y N Blood Disorder/Hemophilia
Y N Convulsions/epilepsy/seizures
Y N Tuberculosis
Y N Developmental Delay
Y N Hearing/Visual Impairment
Y N Emotional/Psychological problems
Y N Kidney/liver conditions
Y N Asbergers's/Autism Spectrum
Y N Diabetes
Y N Heart Murmur/Heart Disease
Y N Cerebral Palsy

Please explain any "yes" answers above: ___________________________________

____

Please list all medications the child is currently taking: _____________________

____

Child's Physician ______________________ Phone # ________________________

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health: Good Fair Poor

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is my responsibility to inform this office of any changes in my child's medical status.

______________________ ____/____/____ ________________

Parent/Guardian Signature Date Relationship