CARLA A. TORNATORE, D.D.S.

REGISTRATION

Name:_____________________________Nickname:____________ Birthdate:_____________Age _____________

Address:_______________________________________City____________State_________Zip_________________

Home Phone:_______________________Cell#______________________Work#____________________________

Name of Responsible Party:__________________________________ Relationship________________________
Billing Address:____

Employer Name:____ Phone___________________________________
Referred by:____

MEDICAL HISTORY

Child's Pediatrician:_______________________________________ Phone:______________________________
Address:____ Date of Last Physical Exam:______________________

Please mark with a check if your child has any of the following:

_____ Visual disorders
_____ Hearing disorders
_____ Asthma
_____ Tuberculosis
_____ Rheumatic heart disease
_____ Heart murmur
_____ Cardiac problems
_____ Liver disease
_____ Convulsions/seizures
_____ Renal/Kidney disease

____ Arthritis
____ Blood disorders
____ Anemia
____ Prolong bleeding
____ Diabetes
____ Fainting
____ Cleft lip/palate
____ Neurological disorders
____ Muscular disorder
_____Malignancies

____ Learning disabilities
____ Venereal disease
____ AIDS or ARC
____ Measles/Mumps
____ Chicken pox
____ Hepatitis
____ Herpes
____ Hyperactivity
____ Jaundice
____ Mitral valve prolapse

Except childhood diseases, does the child have any diseases NOT mentioned?___________________________
List all allergies (including medications):____
List all medications child is presently taking:____

DENTAL HISTORY

Is this your child's first visit to the dentist?_______ If no, dental last exam date__________________________________
Any injuries to the teeth or jaw?_______ If yes, please explain?____
Age patient stopped bottle/breast feeding_____________________ Is child taking vitamins or fluoride?_______________
How often does your child brush his/her teeth?_______________ By whom?_____________________________________
Is there anything else about your child that you think we should know in order to better treat your child?______________
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Your child is a minor: therefore, it is necessary that signed permission be obtained from a parent or guardian before dental care can begin. I attest to the accuracy of the information on this page and I grant Dr. Tornatore permission to provide my child with dental treatment as deemed necessary. If my child ever has a change in his/her health or a change with his/her medications, I will inform the doctor at the next appointment. I authorize release of any information concerning my child's dental health care to another dentist or physician or for the administering claims for dental insurances. I understand that I am financially responsible for payments in full for all accounts.

Parent's Signature:____ Date:_____________________