Peter Gurr, D.D.S. & Scott Jensen, D.D.S.
Specialists in Pediatric Dentistry

Hidayat Nagori, B.D.S., A.B.O.
Specialist in Orthodontics

15303 Huebner Rd. Bldg 17, San Antonio, TX 78248
T: 210.696.2563 F: 210.764.7226

PATIENT REGISTRATION

TODAY'S DATE: ____________________

CHILD'S NAME: ____________________ D.O.B: ____________ SEX: ______

BEST CONTACT #: ____________________ 2NDARY #: ____________________

ADDRESS: ____________________ CITY: ____________ ZIP: ______

EMAIL ADREESS: ____________________

MOTHER: ____________________ D.O.B: ____________ SSN: ____-____-____

ADDRESS: ____________________ CITY: ____________ ZIP: ______

FATHER: ____________________ D.O.B: ____________ SSN: ____-____-____

ADDRESS: ____________________ CITY: ____________ ZIP: ______

EMERGENCY CONTACT/3RD PARTY AUTHORIZATION: ____________________

RELATIONSHIP TO PATIENT: ____________________ CONTACT #: ____________________

HOW DID YOU HEAR ABOUT OUR OFFICE? : ____________________

MEDICAL INFORMATION

_____ ADD/ADHA
_____ ALLERGIES __FOOD __LATEX __ SEASONAL
_____ ALLERGY TO NUTS
_____ ALLERGY TO PENICILLIN
_____ ASTHMA
_____ AUTISM
_____ BLEEDING PROBLEMS
_____ BLOOD TRANSFUSIONS
_____ BIRTH DEFECTS
_____ CEREBRAL PALSY
_____ CHRONIC RESPIRATORY PROBLEMS
_____ CLEFT LIP/PALATE
_____ CONVULSIONS/SEIZURES
_____ CYSTIC FIBROSIS
_____ DEVELOPMENTALLY DELAYED
_____ DIABETES
_____ DEPRESSION/ANXIETY
_____ EPILEPSY
_____ GERD/ACID REFLUX
_____ HEARING DISORDER
_____ HEART DISEASE
_____ HEART MURMUR
_____ HEPATITIS (TYPE_____)
_____ HIGH FEVER
_____ HIV
_____ HOSPITALIZATION
_____ IMMUNODEFICIENCY
_____ KIDNEY DISEASE
_____ LEARNING DISABLED
_____ LIVER DISEASE
_____ RHEUMATIC FEVER
_____ SCARLET FEVER
_____ SENSORY INTEGRATION DISORDER
_____ SPEECH DISORDER
_____ SURGERY
_____ TUBERCULOSIS
_____ OTHER – PLEASE EXPLAIN BELOW

____

____

Welcome to Fun!

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PHYSICIANS NAME: ______________________ PHONE: ______________

CURRENT MEDICATIONS: ______________________________________

MEDICATION ALLERGY: ______________________________________

PRIMARY DENTAL INSURANCE

SUBSCRIBER'S NAME: ______________________ D.O.B: ______________

SUBSCRIBER'S EMPLOYER: ______________________ RELATION TO PATIENT: ______________

INSURANCE COMPANY NAME: ______________________ PHONE: ______________

INSURANCE ADDRESS: ______________________________________

GROUP #: ______________________ MEMBER ID #: ______________________

SECONDARY DENTAL INSURANCE

SUBSCRIBER'S NAME: ______________________ D.O.B: ______________

SUBSCRIBER'S EMPLOYER: ______________________ RELATION TO PATIENT: ______________

INSURANCE COMPANY NAME: ______________________ PHONE: ______________

INSURANCE ADDRESS: ______________________________________

GROUP #: ______________________ MEMBER ID #: ______________________

Any additional signatures for the Notice of Privacy Practices, Consent for Treatment, and Office Policies will be signed separately within the office.

Please ensure that you arrive a few minutes early to your new patient appointment so that we can complete the remaining signatures needed.

Thank you

I authorize that all information given is accurate and correct to the best of my knowledge.

______________________________________ ______________________

Signature of Parent/Legal Guardian Date Signed

Welcome to Fun!