RUSSELL S. POLLINA, D.D.S., P.C.
PEDIATRIC DENTISTRY & ORTHODONTICS
601 W.CENTRAL RD.
SUITE 4
MT. PROSPECT, IL 60056
(847) 392-2457

18 E.DUNDEE RD., BLDG. 5
SUITE 100
BARRINGTON, IL 60010
(847) 382-1720

CHILD'S REGISTRATION AND HISTORY

PATIENT HISTORY

Patient's Name _____ D.O.B. _____ Age _____

Preferred Name _____ Sex _____ Place of Birth _____

Patient's Address _____ Phone _____
STREET CITY STATE ZIP

Father's Name _____ Social Security # _____
DATE OF BIRTH

His Address _____ Phone _____

Employer's Name & Address _____ Phone _____

Mother's Name _____ Social Security # _____
DATE OF BIRTH

Her Address _____ Phone _____

Employer's Name & Address _____ Phone _____

Phone numbers for confirmation of appointment _____ Drivers License # _____

With whom does the patient live? _____

Names and ages of brothers _____

Names and ages of sisters _____

Dental Insurance? Yes _____ No _____ Number _____

Person responsible for account if other than above _____

Address _____ Phone _____

Child's Physician _____ Address _____ Phone _____

Family Dentist _____ Phone _____

Whom may we thank for referring you to our office ☐ Doctor ☐ Parent ☐ Patient ☐ D.D.S.

Name and Address _____

Patient's School _____ Favorite Toy _____

Favorite game/sport _____ Favorite Hobby _____

Favorite fictional character _____

Describe your child's temperament _____

Any social or school difficulties? _____

HEALTH HISTORY

	Yes	No	Up-date
A. Is your child in good health?			
B. Does your child have regular medical exams?			
C. Is your child up to date with Immunizations?			
D. Is your child presently undergoing medical treatment? If so, for what? _____			
E. Is your child presently taking any medications? If so, what? _____			
F. Has your child experienced any unfavorable reaction to medicine? If so, what? _____			
G. Has your child ever been hospitalized? If so, why? _____			
H. Is your child allergic to anything? If so, what? _____			
I. Has your child ever received any blood/blood products? If so, what date? _____			
J. Is there any chance your teenager may be pregnant?			
K. Does your child experience recurrent headaches?			
L. Does your child have any emotional, mental or nervous disorders?			

Does your child now have or has he/she ever had any of the following?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Abnormal Bleeding	☐	☐	Chicken Pox	☐	☐	Heart Murmer	☐	☐	Poor Coordination
☐	☐	Anemia	☐	☐	Chronic Sinusitis	☐	☐	Hemophilia	☐	☐	Respiratory disease
☐	☐	Asthma	☐	☐	Convulsions/Siezures	☐	☐	Hepatitis	☐	☐	Rheumatic Fever
☐	☐	Birth Defects	☐	☐	Diabetes	☐	☐	Hyperactivity	☐	☐	Sickle Cell Disease or Trait
☐	☐	Bladder Disease	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Sight Disorders
☐	☐	Blood Disorders	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Brain Damage	☐	☐	Frequent Earaches	☐	☐	Mental Retardation	☐	☐	Veneral Disease
☐	☐	Cancer/Tumors	☐	☐	Hearing Disorders	☐	☐	Mononucleosis	☐	☐	AIDS or AIDS rel. symptoms
☐	☐	Cerebral Palsy	☐	☐	Heart Disease	☐	☐	Mumps	☐	☐	Other _____

OVER

DENTAL HISTORY

Please answer the following questions:

	Yes	No
Any injuries to mouth/teeth/head	_____	_____
Any mouth habits such as:	_____	_____
thumbsucking?	_____	_____
finger sucking?	_____	_____
nail biting?	_____	_____
nursing bottle habits?	_____	_____
pacifier?	_____	_____
lip sucking?	_____	_____
tongue sucking?	_____	_____
Any unusual speech habits?	_____	_____
Does child brush teeth daily?	_____	_____
Do you assist with tooth brushing?	_____	_____
How often? _____	_____	_____
Is dental floss used?	_____	_____
How often? _____	_____	_____
Are disclosing tablets used?	_____	_____
Is fluoride taken/used in any form?	_____	_____

What toothpaste is usually used:

_____

Please check of your child has or had:

Cavities	( )
Toothache	( )
Teeth sensitive to sweets	( )
Teeth sensitive to hot	( )
Teeth sensitive to cold	( )
Frequent mouth/lip blisters	( )
Bleeding gums	( )
Teeth bumped	( )
Crooked teeth	( )
Discoloration of teeth	( )
Bad breath	( )
Food packing	( )
Mouth breathing	( )
Grinding of teeth	( )
Clicking or popping of jaw	( )
Swollen gums	( )
Other dental problems:	( )

_____

	Yes	No
1. Was your child bottle-fed?	_____	_____
2. Is this your child's first dental visit?	_____	_____
If no, date of last visit _____		
and where _____		
3. Has your child had an unfavorable experience in a dental office?	_____	_____
4. Does your child have a toothache?	_____	_____
5. Do you consider your child generally high strung or nervous?	_____	_____

6. Purpose of this appointment _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and all necessary dental service can be started and accomplished by Dr. Pollina. Authorization is hereby granted as such. Furthermore, I will be responsible for any bill incurred to this child for dental treatment.

DATE _____ **SIGNATURE** _____
parent or guardian

OUR OFFICE POLICY:
The following is a statement or our financial policy which we require you to read and sign prior to any treatment.

- **PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CREDIT CARDS, CASH, CHECKS, OR DENTAL INSURANCE**

REGARDING INSURANCE:
We may accept assignment of insurance benefits with verified coverage. We also reserve the right to require 50% of the bill to be paid at time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid for your account in full within 60 days, the balance will automatically be billed to you. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable by your insurance policy. Regarding managed ppo plans where we are a participating provider, all CO-pays and deductibles are due at time of treatment.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

DATE _____ **SIGNATURE** _____
parent or guardian