



FLORIDA DEPARTMENT OF HEALTH IN BAY COUNTY
CHILDREN'S DENTISTRY CLINIC

PATIENT REGISTRATION

NOTE: PARENT OR GUARDIAN MUST STAY ON PREMESIS WHILE SERVICES ARE RENDERED

PATIENT'S LAST NAME FIRST NAME MI DOB:

HOME ADDRESS Zip CODE

MAILING ADDRESS

EMAIL ADDRESS TO RECEIVE EMAIL APPOINTMENT REMINDERS

PLEASE LIST SEVERAL TELEPHONE NUMBERS WE CAN USE TO CONFIRM YOUR CHILDS APPOINTMENT. We will attempt to call, email or text to remind you of the appointment.

HOME PHONE # CELL PHONE # OTHER PHONE # OTHER PHONE #

SEX M F AGE SOCIAL SECURITY NUMBER

HAS YOUR CHILD SEEN A DENTIST IN THE LAST 6 MONTHS? YES NO
IF YES, WHICH DENTIST DID YOUR CHILD SEE?
HAS YOUR MEDICAID DENTAL INSURANCE CHANGED IN THE LAST 6 MONTHS? YES NO
IF YES, WHAT PREVIOUS MEDICAID PLAN DID YOUR CHILD HAVE?

PARENT OR GUARDIAN'S NAME

RELATIONSHIP TO PATIENT

IF YOU ARE NOT THE PARENT OR GUARDIAN, WHAT IS YOUR NAME

WHAT IS YOUR RELATIONSHIP TO THE PATIENT

PRESCRIPTIONS: IF NEEDED TODAY, WHAT PHARMACY DO YOU USE?

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COMMUNICATION PREFERENCE: (please initial all that apply)

I authorize you to contact me at the address and phone numbers above and optionally authorize you to communicate medical matters for me by the following methods:

- School by the School Nurse. Provide School Name
Medical information may be fax to others as deemed necessary for treatment, payment or healthcare operations should the need arise or as I request.
Bay CHD Children's Dentistry Clinic staff may contact me at any method above regarding me or my child's healthcare, appointments, reminders, changes in appointments, cancellations, or upcoming events that may be of interest to me.

NOTE: It is very important we are able to reach you to confirm your appointment. We have a 24-hour Voice Message Box for your convenience. If you need to cancel or reschedule your appointment, please give us a call at 872-4455 prompt 1 prompt 2. If we do not hear from you, the appointment will be considered a "broken appointment"

Patient or Guardian Signature/Relationship Date

FDOH Children's Dentistry Clinic Staff Signature Date

PARENT OR GUARDIAN, PLEASE HAVE THE FOLLOWING READY TO GIVE TO THE INTAKE CLERK:

- ID/driver's license
Child's Medicaid card/social security card
Guardianship Paperwork (If not legal parent)
Temporary Custodial Paperwork

THANK YOU FOR THE OPPORTUNITY TO PROVIDE YOUR CHILD'S DENTAL HEALTH CARE