CHILD REGISTRATION AND HISTORY (0-14 years)

Date__________________ Child's Name____

Birth Date_______________ SSN________________________ Home Phone_____________

Street ______________________ City___________________ State______ Zip________

Father's Name_________________________Cell #________________Work # ______________

Father's Address (if not same as above) ____

Mother's Name_______________________ Cell #_______________ Work #_______________

Mother's Address (if not same as above) ____

Person financially responsible (if other than parent)____________________________________

Street ______________________ City___________________ State______ Zip________

Home Phone __________________Cell #__________________Work # __________________

If new patient, whom may we thank for referring you____________________________________

DENTAL INSURANCE INFORMATION

Name of Dental Insurance____________________________________ Group #_________

Subscriber ID ____________________

Name of Subscriber________________ Birthdate______________ SSN______________

Secondary Dental Insurance__________________________________ Group #_________

Subscriber ID ____________________

Name of Subscriber________________ Birthdate______________ SSN______________

I hereby authorize payment of dental benefits made directly to the dentist indicated.

____ ____________________

Signed (Insured Person) *Date*

DENTAL HISTORY

Date of last dental visit _______________ For what service____

	Yes	No
Has child complained about dental problems? If so, please describe ______________________________	❑	❑
Any unhappy dental experiences? If so, please describe ____	❑	❑
Any injuries to mouth, teeth, head? If so, please describe ______________________________________	❑	❑
Any mouth habits (thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.)	❑	❑
Any unusual speech habits? If so, please describe ____	❑	❑
Any lost teeth? If so, please describe ____	❑	❑
Have missing teeth been replaced? If so, please describe _______________________________________	❑	❑
Orthodontic appliances worn now or in the past? If so, please describe ___________________________	❑	❑
Does child brush teeth daily?	❑	❑
Do you assist child with tooth brushing? If so, how often ____	❑	❑
Is dental floss used? If so, how often ____	❑	❑
Is fluoride taken in any form? If so, please describe ____	❑	❑
Has child ever used nitros (laughing gas)?	❑	❑

Child's attitude toward dentistry ____

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HEALTH HISTORY

Child's Physician __________________ Address__________________________________ Phone_______________

Date of last physical exam _______________ Results ____

	Yes	No
Is child under care of physician now? If so, please describe ______________________________________	❑	❑
Is child receiving any medication or drugs? If so, please describe __________________________________	❑	❑
Is there any excessive bleeding when cut? If so, please describe ___________________________________	❑	❑
Has child ever been hospitalized? If so, please describe ____	❑	❑
Has child ever had surgery? If so, please describe ____	❑	❑
Is there any allergy to penicillin or other drugs? If so, please describe ____________________________	❑	❑
Are there other allergies (food, pollen, animals, dust, etc.)? If so, please describe __________________	❑	❑
Does child have good physical coordination?	❑	❑
Are there any emotional problems? If so, please describe ______________________________________	❑	❑

Has the child had any history of or difficulty with any of the following:

___AIDS	___Chronic Sinus	___Heart Murmur	___Mastoid	___Tuberculosis
___Anemia	___Convulsions	___Heart (other)	___Measles	___Venereal Disease
___Asthma	___Diabetes	___HIV Infection	___Mononucleosis	___Other
___Bladder	___Epilepsy	___Kidney	___Mumps	
___Cerebral Palsy	___Fainting	___Liver	___Rheumatic Fever	
___Chicken Pox	___Hearing	___Malignancies	___Thyroid	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed:

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To the best of my knowledge, the above information is complete and correct. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. *I understand that a 1.5% Service Charge may be assessed on the unpaid balance of 60 days and over, and also liable for legal and collection fees. I understand that I am responsible for payment in full upon completion of each procedure. My insurance will be billed, if applicable, however, I am responsible for all charges not covered by my insurance.*

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Signature of parent or guardian *Date*