CHILD'S REGISTRATION AND HISTORY

PIN

DATE ____________________

CHILD

CHILD'S NAME ____________________ NICKNAME ____________________

DATE OF BIRTH ____________ AGE ______ SEX: M F GRADE ________ SCHOOL ____________________

RESIDENCE ADDRESS ____________________ CITY ____________ STATE _____ ZIP ________

EMAIL ____________________

DAD

FATHER'S FULL NAME ____________________ FATHER'S SOCIAL SECURITY# ____________________

DATE OF BIRTH ____________________

FATHER EMPLOYED BY____________________ OCCUPATION ____________________ HOW LONG __________

FATHER'S BUSINESS ADDRESS ____________________ CITY ____________ STATE _____ ZIP ________

FATHER'S HOME PHONE ____________ BUSINESS PHONE ____________ CELL PHONE ____________

MOM

MOTHER'S FULL NAME ____________________ MOTHER'S SOCIAL SECURITY# ____________

DATE OF BIRTH ____________________

MOTHER EMPLOYED BY____________________ OCCUPATION ____________________ HOW LONG __________

MOTHER'S BUSINESS ADDRESS ____________________ CITY ____________ STATE _____ ZIP ________

MOTHER'S HOME PHONE ____________ BUSINESS PHONE ____________ CELL PHONE ____________

FAMILY

OTHER CHILDREN IN YOUR FAMILY (Names, ages)____________________

ARE THEY CURRENTLY PATIENTS HERE? ❑ YES ❑ NO

NAME AND PHONE NUMBER OF NEAREST RELATIVE OR FRIEND IN CASE OF EMERGENCY ____________

____

INSURANCE

DO YOU HAVE DENTAL INSURANCE? ❑ YES ❑ NO

WHICH PARENT IS THE PRIMARY INSURANCE CARRIER? ❑ FATHER ❑ MOTHER

INSURANCE COMPANY ____________________

POLICY

INSURANCE POLICY

WE FILE YOUR PRIMARY INSURANCE AS A COURTESY. YOUR PORTION WILL BE REQUIRED AT EACH VISIT. KEEP IN MIND, YOUR PORTION IS ONLY AN ESTIMATE THEREFORE, YOU ARE ULTIMATELY RESPONSIBLE FOR WHATEVER YOUR INSURANCE DOES NOT PAY. IF WE HAVE NOT VERIFIED YOUR INSURANCE PRIOR TO YOUR VISIT, PAYMENT IS DUE IN FULL AN ITEMIZED RECEIPT WILL BE FURNISHED FOR YOUR DIRECT REIMBURSEMENT FROM YOUR INSURANCE COMPANY.

NON-INSURANCE POLICY

TO REDUCE THE INCREASING COST OF BILLING, PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. THANK YOU FOR YOUR COOPERATION.

REFERRAL

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________

IF PERSONAL REFERRAL, PLEASE INDICATE CHILD'S NAME ____________________

OVER

Children's Dentistry

CHILD'S PEDIATRICIAN ______________________ PHONE# ______________

DATE OF LAST PHYSICAL EXAM ______________ RESULTS ______________________

DENTAL

	YES	NO
IS THIS YOUR CHILD 'S FIRST VISIT TO THE DENTIST?	❑	❑
IF NO, WHAT IS THE DATE OF LAST DENTAL VISIT? ______________		
WHAT WAS DONE PREVIOUSLY (FILLINGS, EXTRACTIONS, SPACE MAINTAINER, ETC.)? ______________		
DOES CHILD HAVE A TOOTHACHE? IF YES, WHEN? (WHILE EATING) (AT NIGHT) (SPONTANEOUS) (WAKE FROM SLEEP)	❑	❑
AT WHAT AGE WAS CHILD OFF THE BABY BOTTLE? ______________		
DOES CHILD BR USH HIS OR HER TEETH DAILY?.........................	❑	❑
DO YOU ASSIST CHILD WITH TOOTH BRUSHING?	❑	❑
HAS YOUR CHILD EVER HAD A PROBLEM WITH TMJ OR TMD?	❑	❑

	YES	NO
IS YOUR WATER FLUORIDATED AT HOME?	❑	❑
DOES YOUR CHILD TAKE FLUORIDE SUPPLEMENTS?	❑	❑
IS DENTAL FLOSS USED?	❑	❑
DOES CHILD HAVE ANY UNUSUAL SPEECH HABITS?..................	❑	❑
DOES CHILD SUCK HIS OR HER THUMB OR FINGER OR HAVE ANY SIMILAR HABITS?	❑	❑
WILL CHILD BE UNCOOPERATIVE? IF YES, EXPLAIN	❑	❑
....		
HAS THE CHILD EVER HAD ANY UNFAVORABLE DENTAL EXPERIENCES? IF YES, EXPLAIN	❑	❑
....		

MEDICAL

	YES	NO
DOES CHILD HAVE A HEALTH PROBLEM?	❑	❑
HAS CHILD BEEN ILL RECENTLY?...	❑	❑
HAS CHILD BEEN UNDER TREATMENT BY A PHYSICIAN RECENTLY?	❑	❑
IF YES , FOR WHAT REASON? ______________		
HAS CHILD EVER BEEN A PATIENT IN A HOSPITAL?.................	❑	❑
IF YES, FOR WHAT REASON? ______________		
DOES CHILD TAKE ANY MEDICINES? IF YES, WHAT KIND.......	❑	❑
______________ WHAT DOSE? ______________		
....		
HAS CHILD EVER REACTED TO ANY MEDICINE, SUCH AS PENICILLIN, ASPIRIN, LOCAL ANESTHESIA (DENTAL INJECTION)?	❑	❑

	YES	NO
IS CHILD ALLERGIC TO ANYTHING? (FOOD, POLLEN, ANIMALS, DUST) IF YES, WHAT	❑	❑
DOES CHILD HAVE ASTHMA?	❑	❑
DOES CHILD HAVE A HEART PROBLEM?	❑	❑
DOES CHILD BLEED EXCESSIVELY WHEN CUT?.......................	❑	❑
DOES CHILD HAVE AN EMOTIONAL, MENTAL OR NERVOUS PROBLEM?...	❑	❑
IS CHILD EITHER PHYSICALLY OR MENTALLY HANDICAPPED?	❑	❑
DOES CHILD HAVE GOOD PHYSICAL COORDINATION?	❑	❑
HAS CHILD EVER HAD A BLOOD OR BLOOD PRODUCT TRANSFUSION?	❑	❑
HAS YOUR PHYSICIAN EVER CAUTIONED YOU AS TO SOME ASPECT OF YOUR CHILD'S HEALTH?..	❑	❑

HAS CHILD EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

❑ HEART DISEASE	❑ KIDNEY	❑ HEMOPHILIA	❑ AIDS/HIV POSITIVE
❑ MALIGNANCIES	❑ LIVER	❑ BLEEDING	❑ FREQUENT/RECURRENT
❑ ANEMIA	❑ EPILEPSY	❑ SICKLE CELL	❑ HEADACHES
❑ HEART MURMUR	❑ CEREBRAL PALSY	❑ CHICKEN POX	❑ ENDOCRINE (GLANDS)
❑ CONVULSION/SEIZURES	❑ CHRONIC SINUS	❑ MUMPS	❑ BIRTH DEFECT
❑ FREQUENT COLDS	❑ DIABETES	❑ MEASLES	❑ FREQUENT INFECTIONS
❑ HEPATITIS	❑ TB.	❑ VISION	❑ STOMACH/G.I.
❑ LUNG/BREATHING	❑ RHEUMATIC FEVER	❑ HEARING	

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASES:

❑ DIABETES	❑ HEART DISEASE	❑ T.B.
❑ CANCER	❑ HEMOPHILIA	❑ AIDS/HIV POSITIVE

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

____

THIS INFORMATION GIVEN BY: ______________________ RELATION TO CHILD: ______________

PARENTAL CONSENT FORM

CONSENT: YOUR CHILD IS A MINOR, THEREFORE IT IS NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL SERVICE CAN BE STARTED. I GRANT THE DOCTOR PERMISSION TO PROVIDE MY CHILD'S DENTAL EXAM AND TREATMENT AND I WILL BE RESPONSIBLE FOR THE COST OF THIS DENTAL CARE. THE INFORMATION ABOVE ISCORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED ______________________
PARENT OR GUARDIAN