

CHILD'S REGISTRATION AND HISTORY

	Children's Dentistry								
	DATE								
CHILD	CHILD'S NAME NICKNAME								
	DATE OF BIRTH AGE SEX: M F GRADE SCHOOL								
공 당	RESIDENCE ADDRESS								
	EMAIL								
	FATHER'S FULL NAME FATHER'S SOCIAL SECURITY#								
	DATE OF BIRTH								
۵	FATHER EMPLOYED BY OCCUPATION HOW LONG								
PA	FATHER'S BUSINESS ADDRESS CITY STATE ZIP								
	FATHER'S HOME PHONE BUSINESS PHONE CELL PHONE								
	MOTHER'S FULL NAME MOTHER'S SOCIAL SECURITY#								
MOM	DATE OF BIRTH								
	MOTHER EMPLOYED BY OCCUPATION HOW LONG								
	MOTHER'S BUSINESS ADDRESS CITY STATE ZIP								
	MOTHER'S HOME PHONE BUSINESS PHONE CELL PHONE								
≥	OTHER CHILDREN IN YOUR FAMILY (Names, ages)								
FAMILY	ARE THEY CURRENTLY PATIENTS HERE? VES NO								
Ŧ	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								
	INSURANCE POLICY								
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								
REFERRAL	TO REDUCE THE INCREASING COST OF BILLING, PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. THANK YOU FOR YOUR COOPERATION.								
	WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?								
R	IF PERSONAL REFERRAL, PLEASE INDICATE CHILD'S NAME								



DATE OF LAST DENT REVIOUSLY (FILLING , ETC.)? A TOOTHACHE? IF YE (SPONTANEOUS) (W CHILD OFF THE BAB' H HIS OR HER TEETH LD WITH TOOTH BRI VER HAD A PROBLEM A HEALTH PROBLE L RECENTLY? DER TREATMENT BY REASON? SEEN A PATIENT IN A REASON? ANY MEDICINES? IF WHA WHA CACTED TO ANY MED I, LOCAL ANESTHESI WAD ANY OF THE FO	THE DEI	NTIST?	YES	NO	IS Y DOO IS E DOO HAN WILL HAS EXF DOO DO	YOUR WATER FLUORIDATED A DES YOUR CHILD TAKE FLUOR DENTAL FLOSS USED?	THOME? DE SUPPLEN L SPEECH HA THUMB OR FII THUMB OR FI	JENTS? NGER OR PLAIN E DENTAL DLLEN, ANIMALS, UT? OR NERVOUS Y HANDICAPPED?	YES O O O O YES O O O O		
DATE OF LAST DENT REVIOUSLY (FILLING , ETC.)? A TOOTHACHE? IF YE (SPONTANEOUS) (W CHILD OFF THE BAB* H HIS OR HER TEETH LD WITH TOOTH BRI VER HAD A PROBLEM A HEALTH PROBLE L RECENTLY? DER TREATMENT BY A REASON? SEEN A PATIENT IN A REASON? ANY MEDICINES? IF WHA* WHA* CACTED TO ANY MED I, LOCAL ANESTHESIA IAD ANY OF THE FO	TAL VIS GS, EXT ES, WH VAKE FF BY BOTT H DAILY RUSHING M WITH EM? A PHYS A HOSE F YES, AT DOSE	TRACTIONS, IEN? (WHILE ROM SLEEP) ITLE? I	YES		DOI IS E DOI DOI HAN WILL HAS EXF DO	DES YOUR CHILD TAKE FLUOR DENTAL FLOSS USED?	L SPEECH HATHUMB OR FII THUMB OR FII THYES, EXI UNFAVORABL G? (FOOD, PC TOBLEM? TELY WHEN CO NAL, MENTAL OR MENTALL SICAL COORI	JENTS? ABITS? NGER OR PLAIN E DENTAL DLLEN, ANIMALS, UT? OR NERVOUS Y HANDICAPPED?	YES	NC	
DATE OF LAST DENT REVIOUSLY (FILLING , ETC.)? A TOOTHACHE? IF YE (SPONTANEOUS) (W CHILD OFF THE BAB* H HIS OR HER TEETH LD WITH TOOTH BRI VER HAD A PROBLEM A HEALTH PROBLE L RECENTLY? DER TREATMENT BY A REASON? SEEN A PATIENT IN A REASON? ANY MEDICINES? IF WHA* WHA* CACTED TO ANY MED I, LOCAL ANESTHESIA IAD ANY OF THE FO	TAL VIS GS, EXT ES, WH VAKE FF BY BOTT H DAILY RUSHING M WITH EM? A PHYS A HOSE F YES, AT DOSE	TRACTIONS, IEN? (WHILE ROM SLEEP) ITLE? I	YES		DOI IS E DOI DOI HAN WILL HAS EXF DO	DES YOUR CHILD TAKE FLUOR DENTAL FLOSS USED?	L SPEECH HATHUMB OR FII THUMB OR FII THYES, EXI UNFAVORABL G? (FOOD, PC TOBLEM? TELY WHEN CO NAL, MENTAL OR MENTALL SICAL COORI	JENTS? ABITS? NGER OR PLAIN E DENTAL DLLEN, ANIMALS, UT? OR NERVOUS Y HANDICAPPED?	YES	NC	
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		HAL INJECTION)?				HAS YOUR PHYSICIAN EVER CAUTIONED YOU AS TO SOME ASPECT OF YOUR CHILD'S HEALTH?					
	OLLOW	ING DISEASES OI	R PROI	BLEMS?							
SE		KIDNEY				HEMOPHILIA		AIDS/HIV POSIT	IVE		
ES		LIVER				BLEEDING		FREQUENT/REC	URRE	NΤ	
		EPILEPSY				SICKLE CELL		HEADACHES			
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OUR FAMILY EVER H	HAD AN	NY OF THE FOLLO	WING	DISEASI	ES:						
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						AIDS/HIV POSITIVE					
			CLUDII	NG DRU	GS, PENI	IDING SURGERY, RECENT IN	JURIES OR A	ANY OTHER INFOR	RMATIC	N	
THIS INFORMATION GIVEN BY:						RELATION TO CHILD:					
HIDU	SEIZURES LDS NG IR FAMILY EVER ANY CURRENT ME OF THAT WE HA GIVEN BY: CHILD IS A MIN FORE ANY NE EXAM AND TRE	BEIZURES LDS NG R FAMILY EVER HAD AN CHILD IS A MINOR, THE FORE ANY NECESSA EXAM AND TREATME	CHEBRAL PAL SEIZURES CHRONIC SINU LDS DIABETES TB. NG REUMATIC FE R FAMILY EVER HAD ANY OF THE FOLLO HEART DISEAS HEMOPHILIA ANY CURRENT MEDICAL TREATMENT IN FOF THAT WE HAVE NOT DISCUSSED. CHILD IS A MINOR, THEREFORE IT IS FORE ANY NECESSARY DENTAL SI EXAM AND TREATMENT AND I WILL	CEREBRAL PALSY SEIZURES	CEREBRAL PALSY SEIZURES CHRONIC SINUS LDS DIABETES TB. NG RHEUMATIC FEVER IR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASE HEART DISEASE HEMOPHILIA ANY CURRENT MEDICAL TREATMENT INCLUDING DRUG FOF THAT WE HAVE NOT DISCUSSED. CHILD IS A MINOR, THEREFORE IT IS NECESSAR FORE ANY NECESSARY DENTAL SERVICE CAN EXAM AND TREATMENT AND I WILL BE RESPONS	GIVEN BY: PARENTAL CONSIDER PARENTAL CONSIDER PARENTAL CONSIDER CHILD IS A MINOR, THEREFORE IT IS NECESSARY THATFORE ANY NECESSARY DENTAL SERVICE CAN BE STAR EXAM AND TREATMENT AND I WILL BE RESPONSIBLE IS TO THE POLICY OF	CHICKEN POX SEIZURES	CEREBRAL PALSY CHICKEN POX CHICKEN POX CHRONIC SINUS MUMPS DIABETES DIABETE	CHICKEN POX	CHICKEN POX	