CHILD'S REGISTRATION AND DENTAL HISTORY

PATIENT'S NAME ______________________ DATE ______________

ADDRESS ______________________ PATIENT'S BIRTHDATE ______________

CITY.STATE.ZIP ______________________ FATHER'S BIRTHDATE ______________

PHONE# ______________________ MOTHER'S BIRTHDATE ______________

EMAIL ______________________

FATHER'S NAME ______________________ SOCIAL SECURITY # ______________

PLACE OF EMPLOYMENT ______________________ ADDRESS ______________

BUSINESS PHONE # ____________ CELL # ____________ PRESENT, POSITION ______________

LENGTH OF EMPLOYMENT ______________________ CONTRACT ID # ______________

DENTAL INSURANCE CO. ______________________ GROUP/POLICY/UNION* ______________

MOTHER'S NAME ______________________ SOCIAL SECURITY # ______________

PLACE OF EMPLOYMENT ______________________ ADDRESS ______________

BUSINESS PHONE # ____________ CELL # ____________ PRESENT, POSITION ______________

LENGTH OF EMPLOYMENT ______________________ CONTRACT ID # ______________

DENTAL INSURANCE CO. ______________________ GROUP/POLICY/UNION* ______________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED ______________________

PHONE #. ______________ RELATION TO PATIENT ______________

WHO SHALL WE THANK FOR REFERRING YOU ______________________

WHO WILL PAY THIS ACCOUNT ______________________

ADDRESS ______________________ PHONE # ______________

UNDER 12

IF CHILD IS UNDER 12 PLEASE FILL OUT THIS SECTION

WHAT IS CHILD'S FAVORITE SPORT ______________ FAVORITE TOY ______________

FAVORITE HOBBY ______________ FAVORITE FICTIONAL CHARACTER ______________

AUTHORIZATION TO PAY BENEFITS TO DENTIST:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE INSURANCE BENEFIT OTHERWISE PAYABLE TO ME FOR HIS SERVICE.

PATIENT SIGNATURE ______________________ DATE ______________

Other Side. Pleas

DATE OF LAST DENTAL VISIT ______________ FOR WHAT SERVICE ______________

YES	NO	
		CHILD'S ATTITUDE TO DENTISTRY ______________
❑	❑	HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS ______________
❑	❑	ANY UNHAPPY DENTAL EXPERIENCES ______________
❑	❑	ANY INJURIES TO MOUTH. TEETH, HEAD ______________
❑	❑	ANY THUMBSUCKING. NAIL BITING, MOUTH BREATHING, BOTTLE/PACIFIER HABITS ______________
❑	❑	HAVE ANY TEETH BEEN LOST OR REPLACED ______________
		HOW OFTEN IS TOOTHBRUSHING DONE ______________ DO YOU ASSIST CHILD ______________
		HOW OFTEN IS FLOSS USED ______________ IS FLUORIDE TAKEN IN ANY FORM ______________
❑	❑	ORTHODONTIC APPLIANCES WORN NOW OR EVER BEFORE ______________
❑	❑	DO YOU DESIRE COMPLETE DENTAL SERVICE FOR CHILD ______________

HEALTH HISTORY

CHILD'S PHYSICIAN ______________ ADDRESS ______________ PHONE ______________

DATE OF LAST PHYSICAL EXAM ______________ RESULTS ______________

YES	NO	
❑	❑	IS CHILD UNDER CARE OF PHYSICIAN NOW ______________
❑	❑	IS CHILD RECEIVING ANY MEDICATION OR DRUGS ______________
❑	❑	IS THERE ANY EXCESSIVE BLEEDING WHEN CUT ______________
❑	❑	HAS THERE EVER BEEN A HEART MURMUR DIAGNOSED ______________
❑	❑	HAS CHILD EVER BEEN HOSPITALIZED ______________
❑	❑	HAS CHILD EVER HAD SURGERY ______________
❑	❑	IS THERE ANY ALLERGY TO PENICILLIN OR OTHER DRUGS
❑	❑	ARE THERE OTHER ALLERGIES: FOOD, POLLEN, ANIMALS, DUST, ETC ______________
❑	❑	ARE THERE ANY EMOTIONAL PROBLEMS ______________

HAS CHILD ANY HISTORY OR OF DIFFICULTY WITH ANY OF THE FOLLOWING:

____ Chronic Sinus	____ Hearing	____ Mastoid	____ Rheumatic Fever	____ Anemia
____ Asthma	____ Convulsions	____ Heart	____ Measles	____ Thyroid
____ Bladder	____ Diabetes	____ Kidney	____ Mononucleosis	____ Tuberculosis
____ Cerebral Palsy	____ Epilepsy	____ Liver	____ Mumps	____ A.I.D.S.
____ Chicken Pox	____ Fainting	____ Malignancies		____ H.I.V. 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.

____

____

May we request release of your child's medical records for our reference? ______________ ❑ Yes ❑ No

This information was discussed with and given by ______________

Relation to Child ______________