

Child Patient Registration

Child Information

Today's Date: _____ Child's Date of Birth: _____

Child's Last Name: _____ First Name: _____ MI: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Parent Information

Mother's Name: _____ Date of Birth: _____

Mother's Employer: _____ SSN: _____

Business Phone: _____ Cell Phone: _____

Father's Name: _____ Date of Birth: _____

Father's Employer: _____ SSN: _____

Business Phone: _____ Cell Phone: _____

Account and Emergency Contact

Name of Person Responsible for this account? _____

Whom may we thank for this referral? _____

Someone to notify in case of emergency: _____ Phone: _____

Dental Insurance

1st Coverage

Employee Name: _____

Date of Birth: _____ SSN: _____

Employer: _____ Yrs.: _____

Name of Insurance Co.: _____

Address: _____

Phone No.: _____

Group No.: _____

2nd Coverage

Employee Name: _____

Date of Birth: _____ SSN: _____

Employer: _____ Yrs.: _____

Name of Insurance Co.: _____

Address: _____

Phone No.: _____

Group No.: _____

Dental History

What is the purpose of this visit? _____

Does your child have a specific dental problem that needs attention now? _____

What is it? _____

How long has it been since your last dental cleaning? _____

Who was your child's previous dentist? _____

Address: _____ Phone No.: _____

Child Patient Registration

Child's Name: _____ Today's Date: _____

Medical History

YES NO

- ☐ ☐ Is child now in good health?
- ☐ ☐ Does your child see a pediatrician or other physician?

Name of physician: _____

Tel. No.: _____

- ☐ ☐ Has child had surgery?
What? _____
- ☐ ☐ Is child subject to heavy bleeding?
- ☐ ☐ Is child subject to nervous disorders?
- ☐ ☐ Fainting?
- ☐ ☐ Seizures?
- ☐ ☐ Dizziness?
- ☐ ☐ Behavior/Learning problems
- ☐ ☐ Is child allergic to penicillin?
- ☐ ☐ or other drugs, anesthetics, latex?
- ☐ ☐ Is child taking any medication?
If yes, what? _____
- ☐ ☐ Does child have a history of diabetes?
- ☐ ☐ Hemophilia? or heart murmur
- ☐ ☐ Heart trouble? or breathing problems
- ☐ ☐ Asthma?
- ☐ ☐ Kidney infection?
- ☐ ☐ Rheumatic fever?
- ☐ ☐ Toothache?

Dental History - Continued

YES NO

- ☐ ☐ Is this the child's first visit to a dentist?
- ☐ ☐ Does your child snack frequently?
- ☐ ☐ Does child eat sweets, such as candy, soda, gum?
- ☐ ☐ Does child have a well-balanced diet?
- ☐ ☐ Does child brush teeth on arising?
- ☐ ☐ Before going to bed?
- ☐ ☐ Right after eating meals?
- ☐ ☐ Do you assist your child with brushing?
- ☐ ☐ Do you have fluoridated water in the home?
- ☐ ☐ Have child's teeth been treated with fluorides?
- ☐ ☐ Does / did your child have any of these habits?
- ☐ ☐ Thumbsucking?
- ☐ ☐ Pacifier?
- ☐ ☐ Lip / cheek biting?
- ☐ ☐ Nail biting?
- ☐ ☐ Were any cavities noted in the past?
- ☐ ☐ Were any teeth (baby or permanent) removed?
- ☐ ☐ Was it suggested that the space be maintained?
- ☐ ☐ Was an appliance placed?
- ☐ ☐ Has child had any injuries to teeth-falls, blows, chips, etc.?
- ☐ ☐ Has child had any unfavorable dental experience?

How many children in your family? _____

- ☐ ☐ Has child been recommended for orthodontics?
- ☐ ☐ Has child had local anesthetic?

Authorization and Release

I have read and answered the above questions to the best of my knowledge, I authorize and request my insurance company to pay the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Parent

Date

Office Use Only

Date	Update
_____	_____
_____	_____
_____	_____
_____	_____