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CHILD REGISTRATION AND MEDICAL HISTORY

(Please Print)

Child's Information

Childs Full Name:____Date:____________________
(last) (first) (middle initial) (nickname)
Child's Address:____Home Phone:____________________
Birthdate:_____________________________________Age:_______ Sex: Male Female
Interests, Hobbies, Sports, etc.:____

Parent/Guardian Information

Name:____Home Phone:___________________Cell:____________________
Address:____City:__________________State:______Zip:__________
Parent/Guardian Birthdate:___________________________________Parent/Guardian SS#:______________________________
Employer:____Work Phone #:__________________
Business Address:____City:__________________State:______Zip:__________
Name of Dental InsuranceCompany:____Group#:_____________________
Secondary Dental Insurance Company:____Group #:_____________________

Dental History

Chief Oral Complaint:____
Date of last dental exam:_______________________________Has the child had any previous unfavorable dental experience? Y N
If yes, explain:____

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING- indicate with an "X"

- □Traumatic injury to mouth or teeth
- □Teeth sensitive to cold, heat, sweets, pressure
- □Bleeding gums How long?________________
- □Food impaction
- □Clenching or Grinding of teeth
- □Swelling or lumps in mouth
- □Frequent blisters on lips or mouth
- □Pain around ear
- □Bad breath
- □Complications from extractions
- □Topical fluoride treatments
- □Orthodontic treatment
- □Mouth Breathing
- □Oral Habits; thumbsucking, fingernail biting, cheek biting, etc.
- □Texture of toothbrush___________
- □Frequency of brushing__________
- □Dental Floss
- □Disclosing tablets or solution
- □Flouride supplements
- □Between meal snacks
- □Well balanced diet

Medical History

Physicians Name:_____________________________Phone #:___________________Date of last physical:___________

DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING- indicate with an "X"

- □Allergy to Penicillin
- □Allergy to other drugs
- □Allergy to anesthetics
- □Any heart ailments
- □Radiation Treatments
- □Excessive bleeding from cut or extraction
- □Anemia or blood problems
- □Asthma
- □Hay Fever
- □Diabetes
- □Kidney problems
- □Liver problems or hepatitis
- □Malignancies or Leukemia
- □Psychiatric care/emotional problems
- □Rheumatic fever
- □Immune system disorder (AIDS, HIV, ARC)
- □Sinus problems
- □Physical or mental handicap
- □Thyroid disorder
- □Eye disorder
- □Tonsillitis
- □Ulcer or colitis
- □Extreme nervousness/apprehension
- □Other______________________

Describe any current medical treatment including drugs taken, even though not listed above:_______________________________
____

APPOINTMENTS: A $75.00 charge may be applied for failed or cancelled appointments without 24 hours prior notification. This fee covers only a small portion of the office overhead, which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

RETURNED CHECKS AND COLLECTION FEES: There will be a $35.00 charge for all returned checks, including non-sufficient funds and stop payment. All collection fees, including court costs and attorney fees, will be charged to the account and will be the parent/guardian's responsibility.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the person responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the person responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill.

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits to which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Parent/Guardian:____Date________________