



# Child

## PATIENT INFORMATION \*\*PLEASE PRINT\*\*

### CHILD REGISTRATION

DATE: \_\_\_\_\_

FULL NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

NICKNAME: \_\_\_\_\_ WORK PHONE (Guardian): \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CELL PHONE (Guardian): \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ EMAIL (Guardian): \_\_\_\_\_

GENDER: M / F    MARITAL STATUS S M D    CHILD'S SSN#: \_\_\_\_\_

WHOM MAY WE THANK FOR YOUR REFERRAL?: \_\_\_\_\_ CHILD'S DOB: \_\_\_\_\_

## GUARDIAN INFORMATION & PERMISSION FOR DENTAL TREATMENT OF MINOR CHILD

MOTHER/GUARDIAN FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

FATHER/GUARDIAN FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

PERSON(S) FINANCIALLY RESPONSIBLE: \_\_\_\_\_ RELATION: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ / TYPE OF RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

I, \_\_\_\_\_ the parent/legal guardian of \_\_\_\_\_ who is a minor, do hereby authorize and consent to any x-rays, examination, anesthetic, dental treatment rendered under the direct or indirect supervision of SUNSHINE FAMILY DENTISTRY as they may deem necessary. This authorization will remain in effect until cancelled in writing.

## HEALTH INFORMATION

PHYSICIAN'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

IS YOUR CHILD CURRENTLY UNDER A PHYSICIAN'S CARE Y / N (Please circle one)    EVER HOSPITALIZED? Y / N (Please circle one)

REASON(S): \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

ANY SPECIAL NEEDS? \_\_\_\_\_ (Females only: Taking birth control? Y / N)

## PRIMARY INSURANCE INFORMATION

EMPLOYED BY: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DENTAL INSURANCE CO: \_\_\_\_\_ INS. CO. PHONE: \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ POLICY HOLDERS SSN# \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY HOLDERS DOB: \_\_\_\_\_

POLICY ID NUMBER: \_\_\_\_\_ RELATION TO POLICY HOLDER: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

EMPLOYED BY: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DENTAL INSURANCE CO: \_\_\_\_\_ INS. CO. PHONE: \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ POLICY HOLDERS SSN# \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY HOLDERS DOB: \_\_\_\_\_

POLICY ID NUMBER: \_\_\_\_\_ RELATION TO POLICY HOLDER: \_\_\_\_\_

**DOES YOUR CHILD HAVE OR HAVE THEY HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO TO EACH.**

Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?"

These include combinations of Lonimim, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis / Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV / Aids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune Deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor / Malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems/Blood Thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement : Hip / Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>DENTAL HISTORY</b>	
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette / Pipe / Cigar / Dip	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blisters on Lips or Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching of Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking or Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator/Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding of Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums Swollen or Tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy / Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain / Jaw Tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or Cheek Biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunt Placed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches (____ x per month)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack (year:_____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to Cold / Heat / Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke (year:_____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or Growth in their Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Valve / Replacement Stent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet / Ankles / Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hepatitis A / B / C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Blood Thinner Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Taking Medication for Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**FEMALES:**

Is your child pregnant?  Yes  No Due Date \_\_\_\_\_  
 Taking birth control pills?  Yes  No

**MEDICATIONS ALLERGIES**

List any medications your child is currently taking and the correlating diagnosis: _____ _____ _____ Pharmacy Name _____ Phone _____	<input type="checkbox"/> Aspirin <input type="checkbox"/> Barbituates (Sleeping Pills) <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____
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I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

**UPDATES (to be filled in at future appointments)**

Has there been any change in your child's health since their last dental appointment?  Yes  No  
 For what condition? \_\_\_\_\_

Is your child taking any new medications?  Yes  No If so, what? \_\_\_\_\_

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your child's health since their last dental appointment?  Yes  No  
 For what condition? \_\_\_\_\_

Is your child taking any new medications?  Yes  No If so, what? \_\_\_\_\_

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_