CHILD'S DENTAL REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient's Name: _____ Date:_____
Last First MI

Nickname:_____ Sex: ☐ Male ☐ Female Birth Date:_____ Age:_____

Social Security #: _____ School:_____ Grade:_____

Hobbies/Sports:_____

Phone (Home): _____ Parent's Names:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Who is responsible for making appointments?

Name:_____ Relation:_____

Home Phone: _____ Work Phone:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Home Phone:_____ Work Phone:_____ Other Phone:_____

PARENT INFORMATION

Who is accompanying you today?_____ Relation:_____

Does this person have legal custody of you? ☐ Yes ☐ No Parents Marital Status:_____

Mother's Information: ☐ Step Mother ☐ Guardian

Name:_____ Birth Date:_____ Age:_____

Home#:_____ Work#:_____ SS#:_____

Employer:_____ Job Title:_____ How long there?_____

Father's Information: ☐ Step Father ☐ Guardian

Name:_____ Birth Date:_____ Age:_____

Home#:_____ Work#:_____ SS#:_____

Employer:_____ Job Title:_____ How long there?_____

Person Responsible for Account:

Name:_____ Relation:_____ SS#:_____

Home#:_____ Work#:_____ DL#:_____

Employer:_____ Job Title:_____ How long there?_____

Billing address: _____
Street Apt#

_____
City State Zip Code

MEDICAL INFORMATION

Child's Physician:_____ Phone: _____

Date of last visit:_____ Has your child had any serious illnesses or operation? ☐ Yes ☐ No

If Yes, describe:_____

Is your child currently under physician care? ☐ Yes ☐ No If yes, describe_____

Has your child ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV positive
- ☐ Anemia
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Epilepsy
- ☐ Cough, persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart problems

_____

- ☐ Abnormal bleeding/hemophilia
- ☐ Immunization current
- ☐ Kidney Disease or malfunction
- ☐ Liver Disease
- ☐ Material allergies (**LATEX** wool, metal, chemicals)
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Thyroid disease or malfunction
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other _____

Do you Pre-medicate for Heart Problems, Artificial Joints, etc? ☐ Yes ☐ No

List Medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Other Medical History/Conditions:

_____

_____

DENTAL HISTORY

What would you like us to do for your child today?_____

Former Dentist:_____ Address:_____Phone:_____

Date of last dental care:_____ Date of last x-rays:_____

How often does your child brush?_____ Floss?_____

Does your child experience pan or discomfort in the jaw joint? ☐ Yes ☐ No

Has your child ever experienced a mouth or chin injury? ☐ Yes ☐ No

Does your child have speech problem?_____

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Child's Habit affecting the mouth or teeth: ☐ Thumb Sucking ☐ Nail Biting ☐ Other_____

Other information about your child's dental health or previous treatment:_____

DENTAL INSURANCE INFORMATION

Primary

Name of Insured: _____ Pt. Relationship to insured:_____
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name/Address: _____

Name of Insurance company:_____

Secondary

Name of Insured: _____ Pt. Relationship to insured:_____
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name/Address: _____

Name of Insurance Company:_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party