



## Child Patient Registration & Patient Medical History

Child's Name \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Gender  Male  Female Birthdate \_\_\_\_\_

### Mother - Contact Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_  
Please Print  
Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_  
Home # \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Father - Contact Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_  
 Same Address  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_  
Please Print  
Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Ext. \_\_\_\_\_  
Home # \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Primary DENTAL Insurance

Does the child have Dental Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_  
Policy Owner Name \_\_\_\_\_ Policy Owner Employer \_\_\_\_\_  
Policy Owner Birthdate \_\_\_\_\_ Group ID # \_\_\_\_\_  
Policy Owner Soc. Sec # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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## Secondary DENTAL Insurance (if applicable)

Does the child have Secondary Dental Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Policy Owner Name \_\_\_\_\_ Policy Owner Employer \_\_\_\_\_

Policy Owner Birthdate \_\_\_\_\_ Group ID # \_\_\_\_\_

Policy Owner Soc. Sec # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Dental History

Reason for seeking dental care at this time: \_\_\_\_\_

Mo/Year of last dental visit: \_\_\_\_\_ Reason: \_\_\_\_\_

Former Dentist or current DDS if visiting? \_\_\_\_\_ City / ST \_\_\_\_\_

How often does child brush?  Once a day  Twice a day  Three times a day

How often does child floss?  1  2  3 →  Day  Week  Month

How does child feel about dental treatment?  Relaxed  Uneasy  Anxious  Tense

Has child ever had Nitrous Oxide (laughing gas) during dental treatment?  No  Yes

Has child ever been requested to take antibiotics or other medications before/after a dental appointment?  No  Yes

Does/Has child ever had any of the following?

- |  |   |
|--|---|
| <input type="radio"/> Aching/Sensitive Teeth | <input type="radio"/> Difficulty Opening    |
| <input type="radio"/> Bleeding Gums          | <input type="radio"/> Gum Infection         |
| <input type="radio"/> Grinding/Clinching     | <input type="radio"/> Oral Surgery          |
| <input type="radio"/> Cold Sores             | <input type="radio"/> Clicking/Popping Jaw  |
| <input type="radio"/> Broken Filling         | <input type="radio"/> Jaw Pain              |
| <input type="radio"/> Loose Teeth            | <input type="radio"/> Orthodontics          |
| <input type="radio"/> Bad Breath             | <input type="radio"/> Periodontal Treatment |
| <input type="radio"/> Dry Mouth              | <input type="radio"/> None                  |
| <input type="radio"/> Areas of Food Traps    |   |

Please indicate any dental concerns:

- |   |   |
|---|---|
| <input type="radio"/> Close gaps between teeth        | <input type="radio"/> Replace missing teeth |
| <input type="radio"/> Straighten/even out front teeth | <input type="radio"/> None                  |
| <input type="radio"/> Whiten teeth                    | <input type="radio"/> Other                 |
| <input type="radio"/> Change shape of teeth           |   |

\_\_\_\_\_  
Please explain

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## Medical History

Physician's Name \_\_\_\_\_

Is child currently under a physician's care?  Yes  No Reason? \_\_\_\_\_

Check the conditions to indicate if child has or has had any of the following:

- |   |   |   |
|---|---|---|
| <input type="radio"/> Artificial Heart Valve    | <input type="radio"/> HIV or AIDS         | <input type="radio"/> Diabetes              |
| <input type="radio"/> Heart Disease             | <input type="radio"/> Herpes              | <input type="radio"/> Epilepsy or Seizures  |
| <input type="radio"/> Heart Murmur              | <input type="radio"/> High Blood Pressure | <input type="radio"/> Fainting/Dizzy Spells |
| <input type="radio"/> Mitral Valve Prolapse     | <input type="radio"/> Stroke              | <input type="radio"/> Psychiatric Treatment |
| <input type="radio"/> Pacemaker                 | <input type="radio"/> Cancer              | <input type="radio"/> Chemical Dependency   |
| <input type="radio"/> Heart Surgery             | <input type="radio"/> Chemotherapy        | <input type="radio"/> Bleeding Problems     |
| <input type="radio"/> Rheumatic / Scarlet Fever | <input type="radio"/> Radiation Therapy   | <input type="radio"/> Circulatory Problems  |
| <input type="radio"/> Artificial Joint          | <input type="radio"/> Glaucoma            | <input type="radio"/> Headaches             |
| <input type="radio"/> Hepatitis A, B, C         | <input type="radio"/> Asthma              | <input type="radio"/> Back Problems         |
| <input type="radio"/> Liver Disease             | <input type="radio"/> Sinus Trouble       | <input type="radio"/> None of the above     |
| <input type="radio"/> Kidney Disease            | <input type="radio"/> Tuberculosis        |   |

Has child taken any medications or injections in the last 3 months? If so, please list below.

\_\_\_\_\_  
\_\_\_\_\_

List Allergies:  Aspirin  Latex  Sulfa  Codeine  Penicillin  None

List any other allergies:

\_\_\_\_\_

How did you hear about our office?  Yelp (Reviews)  Google (Reviews)  Media Ad  
 Other \_\_\_\_\_  
 Friend/Family/Patient \_\_\_\_\_

### Acceptance of Terms

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand financial arrangements must be made in advance. I am personally responsible for payment of all fees for dental services in this office regardless of insurance coverage. Payment is due when services are rendered. All emergency services or any dental service performed without prior financial arrangements must be paid for at the time services are performed.

- I have read and accept the above conditions

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date

*Thank you!*