Child Dental Registration & History

Patient Information

Date_____
Patient Name: _____ _____
Last Name First Name Middle Initial Nickname
Sex: Male ____ Female ____ Birth date: _____
Address: _____ Apt/Unit: _____
City: _____ State: _____ Zip code: _____
Person financially responsible: _____ Home #: _____ Work #: _____
Whom may we than for referring you? _____
Would you like an appointment confirmation text and email? Yes ___ No ___
If yes, to whom should we send it? _____

Dental Insurance

Father/Guardian's Name _____
Birthdate: _____ SSN # _____
Address (if different from patient's) _____
Home # _____ Work # _____
Cell #_____ Email: _____
Do you have dental insurance/coverage for this child? Yes _____ No_____
If yes, is it primary or secondary? _____
Insurance Co. Name & Phone # _____
Insurance Co. Address: _____
Group # _____ ID# _____

Mother/Guardian's Name _____
Birthdate: _____ SSN # _____
Address (if different from patient's) _____
Home # _____ Work # _____
Cell #_____ Email: _____
Do you have dental insurance/coverage for this child? Yes _____ No_____
If yes, is it primary or secondary? _____
Insurance Co. Name & Phone # _____
Insurance Co. Address: _____
Group # _____ ID# _____

Dental History

Date of last visit _____ For what service? _____
Any oral habits such as mouth breathing, pacifier, thumbsucking, sleeping with a bottle, nail biting? _____
_____

Does child brush teeth daily?	Yes ___	No ___
Does child floss daily?	Yes ___	No ___
Is fluoride taken in any form?	Yes ___	No ___
Has child complained about dental problems?	Yes ___	No ___
Any injuries to mouth, teeth, head?	Yes ___	No ___
Any unhappy dental experiences?	Yes ___	No ___

Medical History

Child's Physician _____ City/State _____ Phone # _____

Date of last physical exam _____

Results: _____

Is child under the care of a physician now? Yes ___ No ___

Ever been hospitalized? Yes ___ No ___

Ever had surgery? Yes ___ No ___

Excessive bleeding when cut? Yes ___ No ___

Medications: _____

_____

Allergies: _____

_____

Has Minor/Child had any history of or difficulty with any of the following? If yes, please check.

___ AIDS/HIV
___ Anemia
___ Asthma
___ Bladder Problems
___ Cancer
___ Cerebral Palsy
___ Convulsions
___ Diabetes
___ Drug/Alcohol Abuse
___ Epilepsy
___ Fainting
___ Hearing Problems
___ Heart Problems
___ Hepatitis
___ Kidney Disease
___ Liver Disease
___ Measles
___ Mononucleosis
___ Mumps
___ Rheumatic Fever
___ Sinus Problems
___ Thyroid Disease

Other: _____

_____

In case of an emergency, whom should we call?

Name: _____ Relationship: _____ Phone # _____

Name: _____ Relationship: _____ Phone # _____