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REGISTRATION & HEALTH HISTORY FORM

Today's Date: _____

WELCOME to our children's dental office with individualized care for infants, toddlers, children and teens! Our focus is on prevention & early management of disease. We are honored that you have entrusted your child's care to us. We take great pride in our expertise in managing children. Should you have any special requests, please inform us & we will do our best to accommodate them.

******* NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service

TELL US ABOUT YOUR CHILD:

Name_____
Last First MI

Goes by _____ □ Male □ Female
Siblings that we treat _____
Child's Birthdate_____ / _____ /_____ Age _____
School _____ Grade _____
Child's Home Address: _____
Child's Home Phone # (_____)_____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name _____
Relationship _____
Do you have legal custody of this child? □ Yes □ No

PARENT ONE - INFORMATION:

Name: _____
Mother Stepmother Guardian DOB: ____ /____ /_____
Employer _____
Home # (_____)_____
Work # (_____)_____
Cell Phone # (_____)_____
Email:_____

PARENT TWO - INFORMATION:

Name: _____
Father Stepfather Guardian DOB: ____ /____ /_____
Employer _____
Home # (_____)_____
Work # (_____)_____
Cell Phone # (_____)_____
Email:_____

PRIMARY DENTAL INSURANCE:

Insurance Name_____
Insurance Co. Address_____
_____
Insurance Co. Phone # (_____)_____

Group # OR Policy #_____
Policy Owners Name_____
Relationship to Patient_____
Policy Owners Birthdate_____ /_____ / _____
Social Security #_____
Policy Owner's Employer_____

SECONDARY DENTAL INSURANCE:

Insurance Name_____
Insurance Co. Address_____
_____
Insurance Co. Phone # (_____)_____

Group # OR Policy #_____
Policy Owners Name_____
Relationship to Patient_____
Policy Owners Birthdate_____ /_____ / _____
Social Security #_____
Policy Owner's Employer_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

If found on the Internet, where did you find us?_____

CHILD'S NAME: AGE:

DENTAL HISTORY:

Is this your child's first visit to the dentist?_____
If not, how long since the last visit?_____
Previous Dentist's Name_____
Were any X-Rays taken at previous dental visits?_____
Any injuries to the teeth, face or mouth?_____
If yes, please explain_____
_____
_____
Why did you bring the child to the dentist today?_____
_____
_____
Any other dental concerns or questions you would like answered?_____
_____
Has the child ever had a serious or difficult problem associated with previous dental work? □ Yes □ No
If yes, please explain_____
_____
_____
Does the child have any of the following habits?

Y N Frequent snacking Y N Night-time feeding
Y N Lip Sucking / Biting Y N Nail Biting
Y N Sleeping with a bottle Y N Thumb/Finger Sucking
Y N Tooth Grinding Y N Snoring
Y N Sippy Cup Use Y N Pacifier Use

HOME DENTAL CARE:

Does your child brush his/her own teeth? □ Yes □ No
How often? _____ x a day
Do you brush your child's teeth? □ Yes □ No
How often? _____ x a day
Does the child floss his/her teeth daily? □ Yes □ No
Do you floss his/her teeth? □ Yes □ No
Is your child able to spit? □ Yes □ No
Is your child taking Fluoride supplements? □ Yes □ No

MEDICAL HISTORY:

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Disabilities/Special Needs
Y N Allergies to Drugs Y N Hearing Impairment
Y N Any Hospital Stays Y N Heart Disease/Murmur
Y N Any Operations Y N Hemophilia/Blood Disorder
Y N Asthma Y N Hepatitis
Y N Cancer Y N HIV + /AIDS
Y N Cong. Birth Defects Y N Kidney/Liver Conditions
Y N Epilepsy Y N Rheumatic/Scarlet Fever
Y N Pregnancy Y N Latex Allergy
Y N Tuberculosis Y N Diabetes
Y N ADD/ADHD Y N Autism

Any other serious medical condition?_____
_____
_____
Please list all drugs the child is currently taking_____
_____
Please list all allergies_____
_____
_____

CHILD'S MEDICAL PROVIDER:

Is the child currently under the care of a physician?
□ Yes □ No
Physician:_____
Physician's Address:_____
_____
_____
Phone # (_____)_____

Please describe the child's current physical health
GOOD FAIR POOR

ACKNOWLEDGEMENT AND AUTHORITY:

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any or all necessary dental services can be rendered. I understand that the information I have given 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 authorize the dental staff to perform the necessary dental services my child may need.
I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICE AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

Signature of Parent or Guardian Date Relationship to Child

NOTES:_____
_____