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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 _______________________________________
Marital Status ◻ single ◻ married ◻ divorced
◻ adoptive parent ◻ foster parent

PARENT ONE - INFORMATION:

Name: ____
Parent Step-Parent Guardian DOB: ____ /____ /________
Employer ____
Home # (_____)______________________________________
Work # (_____)_______________________________________
Cell Phone # (_____)__________________________________
Email:____

PARENT TWO - INFORMATION:

Name: ____
Parent Step-Parent Guardian DOB: ____ /____ /_______
Employer ____
Home # (_____)______________________________________
Work # (_____)_______________________________________
Cell Phone # (_____)__________________________________
Email:____

PRIMARY DENTAL INSURANCE:

Insurance Name______________________________________
Insurance Co. Address_________________________________
____
Insurance Co. Phone # (_______)________________________
Group # ____
Policy Owners Name__________________________________
Relationship to Patient_______________________________
Policy Owners Birthdate_______ /_______ / _____________
Social Security / ID #_________________________________
Policy Owner's Employer______________________________

SECONDARY DENTAL INSURANCE:

Insurance Name______________________________________
Insurance Co. Address_________________________________
____
Insurance Co. Phone # (_____)________________________
Group # ____
Policy Owners Name__________________________________
Relationship to Patient_______________________________
Policy Owners Birthdate_______ /_______ / _____________
Social Security / ID #_________________________________
Policy Owner's Employer______________________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

____

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__________________________________

____

____

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

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 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

Who is accompanying the child today? (Relationship) ______________________________________

NOTES:____

____

CHILD'S NAME:______________________________AGE:______________