Child Registration

We strive to make each of your child's visits pleasant and comfortable.
Please fill out this form completely in ink.

Your Child

Child's Name ____________________
Nickname ____________ Sex __M __F
Birthdate ______________ Age _____
Child's Address ____________________
City ____________ St __ Zip ______
Phone ____________________

Responsible Party

Name ____________________
Relationship ____________________
Address ____________________
City ____________ St __ Zip ______
Phone ____________ Cell ____________
Work Phone ____________________

Mother __ Stepmother __ Guardian

Name ____________________
Home Phone ____________ Cell ________
Work Phone ____________ Ext______
Address ____________________
City ____________ St __ Zip ______
Employer ____________________
Occupation ____________________
SS#/ID ____________________
Marital Status __S __M __D __W
Email ____________________

Father __ Stepfather __ Guardian

Name ____________________
Home Phone ____________ Cell ________
Work Phone ____________ Ext______
Address ____________________
City ____________ St __ Zip ______
Employer ____________________
Occupation ____________________
SS#/ID ____________________
Marital Status __S __M __D __W
Email ____________________

Primary Insurance

Insured's Name ____________________
Relationship ____________________
Birthdate ____________________
SS#/ID ____________________
Employer ____________________
Insurance Co. ____________________
Group # ____________________
Insur Address ____________________
City ____________ St __ Zip ______

Additional Insurance

Insured's Name ____________________
Relationship ____________________
Birthdate ____________________
SS#/ID ____________________
Employer ____________________
Insurance Co. ____________________
Group # ____________________
Insur Address ____________________
City ____________ St __ Zip ______

Child's Dental & Health History

Your Child's overall health as well as any medications which your Child takes could have an important interrelationship with the dental care your Child receives. Please answer each of the following questions completely.

Name of Child's physician____

How often does your Child brush his/her teeth? _______ x day

Does your Child have any oral habits such as:

______ thumb/finger sucking ______ bite/chew nails ______ grind teeth

Is this your Child's first visit to the dentist? ______ YES ______ NO

If NO, who was previous dentist and approximate date of last visit?

____

Does your Child have a fear of Dentistry? ______ YES ______ NO

Is your Child currently taking any medications? ______ YES ______ NO

If YES, please list all medications: ______________________________________

____

Is your Child allergic to any of the following?

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal

_____ Anesthetics (Local) _____ Latex _____ Other ___________________________

Does your Child have, or have they had, any of the following: (please circle)

Anaphylaxis	Cortisone Medication	Hemophilia	Rheumatic Fever
Anemia	Diabetes	Hepatitis A or B or C	Scarlet Fever
Artificial Heart Valve	Endocarditis	Hives or Rash	Sickle Cell Disease
Artificial Joint	Epilepsy or Seizures	Hypoglycemia	Spina Bifida
Asthma	Excessive Bleeding	Irregular Heartbeat	Stomach/Intestinal Disease
Blood Transfusion	Excessive Thirst	Kidney Problems	Thyroid Disease
Bruise Easily	Fainting Spells/Dizziness	Leukemia	Tonsillitis
Cancer	Frequent Cough	Liver Disease	Tumors or Growths
Cold Sores/Blisters	Hay Fever	Lung Disease	Yellow Jaundice
Congenital Heart Disorder	Heart Murmur	Mitral Valve Prolapse	
Convulsions	Heart Trouble	Radiation Treatments	

Has your Child ever had any serious illness not listed above? ______ YES ______ NO

If YES, please explain ____

____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the dentist staff to perform the diagnostic procedures and treatment necessary for proper dental care.

Signature of Patient, Parent or Guardian

____ **Date** ______________