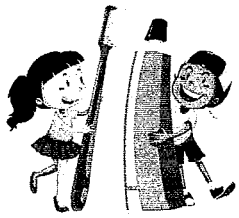
SCHMIDT
FAMILY DENTAL



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 _____ Acrylicl

_____ Metal _____ Latex _____ Sulfa Drugs _____ Local Anesthetics Other _____

Does your Child have, or have they had, any of the following:

	Yes	No
AIDS or HIV Infection	☐	☐
Alzheimer's Disease	☐	☐
Drug Addiction	☐	☐
Angina	☐	☐
Epilepsy or Seizures	☐	☐
Hives or Rash	☐	☐
Sickle Cell Disease	☐	☐
Kidney Problems	☐	☐
Frequent Headaches	☐	☐
Cancer	☐	☐
Chest Pains	☐	☐
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Heart Trouble/Disease	☐	☐
C.Difficile	☐	☐

	Yes	No
Cortisone Medicine	☐	☐
Diabetes	☐	☐
Hepatitis B or C	☐	☐
Emphysema	☐	☐
High Cholesterol	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Thyroid Disease	☐	☐
Heart Attack/Failure	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Psychiatric Care	☐	☐

	Yes	No
Hemophilia	☐	☐
Hepatitis A	☐	☐
Renal Dialysis	☐	☐
High Blood Pressure	☐	☐
Artificial Heart Valve	☐	☐
Excessive Thirst	☐	☐
Irregular Heartbeat	☐	☐
Stomach/Intestinal Disease	☐	☐
Stroke	☐	☐
Chemotherapy	☐	☐
Osteoporosis	☐	☐
Pain in Jaw Joints	☐	☐
Parathyroid Disease	☐	☐
Yellow Jaundice	☐	☐

	Yes	No
Radiation Treatments	☐	☐
Anaphylaxis	☐	☐
Anemia	☐	☐
Arthritis/Gout	☐	☐
Excessive Bleeding	☐	☐
Hypoglycemia	☐	☐
Blood Disease	☐	☐
Breathing Problems	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Tuberculosis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Infective Endocarditis	☐	☐
Other _____	☐	☐

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** _____