DATE _____

CHILD'S REGISTRATION AND HISTORY

CHILD'S NAME _____NICKNAME _____

DATE OF BIRTH _____AGE _____ SEX: M F GRADE_____SCHOOL _____

RESIDENCE ADDRESS _____CITY _____STATE _____ ZIP_____

FATHER'S FULL NAME _____ FATHER'S SOCIAL SECURITY #_____

DATE OF BIRTH _____ EMAIL ADDRESS_____

FATHER EMPLOYED BY _____OCCUPATION _____ HOW LONG_____

FATHER'S BUSINESS ADDRESS _____CITY _____ STATE _____ ZIP_____

FATHER'S HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

MOTHER'S FULL NAME _____ MOTHER'S SOCIAL SECURITY #_____

DATE OF BIRTH _____ EMAIL ADDRESS _____

MOTHER EMPLOYED BY _____OCCUPATION _____ HOW LONG_____

MOTHER'S BUSINESS ADDRESS _____CITY _____ STATE _____ ZIP_____

MOTHER'S HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

OTHER CHILDREN IN YOUR FAMILY (Names, ages) _____

ARE THEY CURRENTLY PATIENTS HERE? ☐ YES ☐ NO

NAME AND PHONE NUMBER OF NEAREST RELATIVE OR FRIEND **IN CASE OF EMERGENCY**

_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF PERSONAL REFERRAL, PLEASE INDICATE CHILD'S NAME _____

DO YOU HAVE **DENTAL INSURANCE?** ☐ YES ☐ NO ***FILE YOUR PRIMARY INSURANCE AS AN OFFICE COURTESY ☐ YES ☐ NO

WHICH PARENT IS THE **PRIMARY INSURANCE CARRIER?** ☐ FATHER ☐ MOTHER

INSURANCE COMPANY NAME, ADDRESS, PHONE NUMBER, ELECTRONIC PAYOR ID NUMBER _____

_____

INSURANCE POLICY

***WE FILE YOUR PRIMARY INSURANCE AS AN OFFICE COURTESY. IN ORDER TO PROVIDE THIS SERVICE IT IS YOUR RESPONSIBILITY TO GIVE ACCURATE INSURANCE INFORMATION. WE WILL NEED YOUR UPDATED INSURANCE INFORMATION BEFORE EACH APPOINTMENT. IF WE HAVE NOT VERIFIED YOUR INSURANCE PRIOR TO YOUR VISIT, PAYMENT IS DUE IN FULL. KEEP IN MIND, YOUR PORTION IS ONLY AN ESTIMATE. THEREFORE, YOU ARE ULTIMATELY RESPONSIBLE FOR WHATEVER YOUR INSURANCE DOES NOT PAY.

NON-INSURANCE POLICY

TO REDUCE THE INCREASING COST OF BILLING, PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. THANK YOU FOR YOUR COOPERATION. WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD. WE ALSO OFFER CAPITAL ONE HEALTH CARE FINANCE.

PLEASE REVIEW OUR FINANCIAL POLICY FORM FOR MORE INFORMATION.

DENTAL QUESTIONS

PLEASE ANSWER ALL QUESTIONS:

IS THIS YOUR CHILD'S **FIRST VISIT** TO THE DENTIST?

☐**YES** ☐**NO**

IF NO, WHAT IS THE DATE OF **LAST DENTAL VISIT?**

_____

WHAT WAS DONE **PREVIOUSLY** (FILLINGS, EXTRACTIONS, SPACE MAINTAINER, ETC)? _____

DOES YOUR CHILD HAVE A **TOOTHACHE**? □**YES** □**NO**

IF YES, **WHEN**? WHILE EATING, AT NIGHT, SPONTANEOUS, WAKE FROM SLEEP _____

AT WHAT AGE WAS CHILD **OFF THE BABY BOTTLE**? _____

DOES CHILD **BRUSH HIS OR HER TEETH DAILY**? □**YES** □**NO**

DO YOU **ASSIST CHILD WITH TOOTH BRUSHING**? □**YES** □**NO**

HAS YOUR CHILD EVER HAD A **PROBLEM WITH JAW JOINT**? □YES □NO

IS YOUR WATER FLOURIDATED AT HOME? □**YES** □**NO**

DOES YOUR CHILD TAKE **FLOURIDE SUPPLEMENTS**? □**YES** □**NO**

IS DENTAL FLOSS USED? □**YES** □**NO**

DOES CHILD HAVE ANY **UNUSUAL SPEECH HABITS**? □YES □NO

DOES CHILD **SUCK HIS OR HER THUMB OR FINGER OR HAVE ANY SIMILAR HABITS**? □YES □NO

WILL CHILD **BE UNCOOPERATIVE**? IF YES, EXPLAIN

_____

HAS THE CHILD EVER HAD ANY **UNFAVORABLE DENTAL EXPERIENCES**? IF YES, EXPLAIN

_____

MEDICAL QUESTIONS

CHILD'S PEDIATRICIAN_____ **PHONE**_____

DATE OF LAST PHYSICAL EXAM _____**RESULTS** _____

PLEASE ANSWER ALL QUESTIONS:

DOES CHILD HAVE A **HEALTH PROBLEM**? □**YES** □**NO**

IF YES, EXPLAIN _____

HAS CHILD BEEN **ILL RECENTLY**? □**YES** □**NO**

HAS CHILD BEEN **UNDER TREATMENT BY A PHYSICIAN RECENTLY**?

□**YES** □**NO**

IF YES, FOR WHAT REASON

_____

HAS CHILD EVER BEEN A **PATIENT IN A HOSPITAL**? □**YES** □**NO**

IF YES, FOR **WHAT REASON AND WHEN**?

_____

DOES CHILD **TAKE ANY MEDICATIONS**? □**YES** □**NO**

IF YES, WHAT KIND _____

WHAT DOSE? _____

HAS CHILD EVER REACTED TO ANY MEDICATIONS, SUCH AS PENICILLIN, ASPIRIN, LOCAL ANESTHESIA (DENTAL INJECTION)? □**YES** □**NO**

IF YES, **TO WHAT**? _____

IS CHILD ALLERGIC TO ANYTHING? (FOOD, POLLEN, ANIMALS, DUST) □**YES** □**NO**

IF YES, **TO WHAT**? _____

DOES CHILD HAVE **ASTHMA**? □**YES** □**NO**

DOES CHILD HAVE A **HEART PROBLEM**? □**YES** □**NO**

DOES CHILD **BLEED EXCESSIVELY** WHEN CUT? □**YES** □**NO**

DOES CHILD HAVE AN **EMOTIONAL, MENTAL OR NERVOUS PROBLEM**? □**YES** □**NO**

IS CHILD EITHER **PHYSICALLY OR MENTALLY HANDICAPPED**? □**YES** □**NO**

DOES CHILD HAVE **GOOD PHYSICAL COORDINATION**? □**YES** □**NO**

HAS CHILD EVER HAD A **BLOOD OR BLOOD PRODUCT TRANSFUSION**? □**YES** □**NO**

HAS YOUR **PHYSICIAN EVER CAUTIONED YOU AS TO SOME ASPECT OF YOUR CHILD'S HEALTH**? □**YES** □**NO**

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

□ HEART DISEASE
□ MALIGNANCIES
□ ANEMIA
□ HEART MURMUR
□ CONVULSIONS
□ SEIZURES
□ FREQUENT COLDS
□ HEPATITIS
□ LUNG/BREATHING
□ KIDNEY/LIVER
□ EPILEPSY
□ CEREBRAL PALSY
□ CHRONIC SINUS
□ DIABETES
□ T.B.
□ RHEUMATIC FEVER
□ HEMOPHELIA
□ BLEEDING
□ SICKLE CELL
□ CHICKEN POX
□ MUMPS
□ MEASLES
□ VISION
□ HEARING
□ AIDS/HIV POSITIVE
□ FREQUENT/RECURRENT HEADACHES
□ ENDOCRINE (GLANDS)
□ BIRTH DEFECT
□ FREQUENT INFECTIOINS
□ STOMACH/G.I.

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASES?

□ DIABETES □ CANCER □ HEART □HEMOPHILIA DISEASE

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NO DISCUSSED_____

_____

THIS INFORMATION GIVEN BY _____**RELATION TO CHILD** _____

PARENTAL CONSENT FORM

IT IS NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL SERVICE CAN BE STARTED. I GRANT THE DOCTOR PERMISSION TO PROVIDE MY CHILD'S DENTAL EXAM AND TREATMENT AND I WILL BE RESPONSIBLE FOR THE COST OF THIS DENTAL CARE. THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PARENT OR GUARDIAN SIGNATURE_____