



**CHILD'S REGISTRATION FORM**

FOR OFFICE USE ONLY  
New Patient \_\_\_ Patient Update \_\_\_ Dental Warranty \_\_\_

Today's Date: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ Parent's Name(s): \_\_\_\_\_  
Home Phone#:(\_\_\_\_) \_\_\_\_\_ Dad's Work:(\_\_\_\_) \_\_\_\_\_ Mom's Work:(\_\_\_\_) \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
School: \_\_\_\_\_ Other family members seen by us: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Child's Favorite Sport, Hobby and/or person: \_\_\_\_\_

**MEDICAL HISTORY**

Physician: \_\_\_\_\_ Is child currently under the care of a physician? \_\_\_  
Please explain: \_\_\_\_\_  
Is your child taking any prescription and/or over the counter drugs? \_\_\_ Yes \_\_\_ No  
Please list each medication that you take: \_\_\_\_\_  
Is your child allergic to any of the following? \_\_\_Aspirin \_\_\_Codeine \_\_\_Dental Anesthetics  
\_\_\_Erythromycin \_\_\_Latex \_\_\_Penicillin \_\_\_Tetracycline \_\_\_Jewelry \_\_\_Metals \_\_\_Seaweed  
Please list any other allergies that your child has: \_\_\_\_\_  
Has your child ever had any of the following diseases, medical problems and/or treatments?  
\_\_\_Anemia \_\_\_Artificial Joints \_\_\_Artificial Valves \_\_\_Asthma \_\_\_Arthritis \_\_\_Bladder \_\_\_Cancer  
\_\_\_Cerebral Palsy \_\_\_Chicken Pox \_\_\_Chemotherapy \_\_\_Congenital Heart Defect \_\_\_Diabetes  
\_\_\_Difficulty Breathing \_\_\_Epilepsy/Convulsions \_\_\_Fainting \_\_\_Fever Blisters/Herpes \_\_\_Hearing  
\_\_\_Heart Surgery \_\_\_Heart Murmur \_\_\_Hemophilia/Abnormal Bleeding \_\_\_Hepatitis \_\_\_High/Low Blood  
Pressure \_\_\_HIV+ /AIDS \_\_\_Kidney Problems \_\_\_Liver \_\_\_Malignancies \_\_\_Mastoid \_\_\_Measles \_\_\_Mitral  
Valve Prolapse \_\_\_Mononucleosis \_\_\_Mumps \_\_\_Rheumatic Fever \_\_\_Severe/Frequent Headaches \_\_\_Sinus  
Problems \_\_\_Tuberculosis  
Any other problems or conditions: \_\_\_\_\_

**SEE REVERSE SIDE**

## DENTAL HISTORY

Date of Last Dental Visit: \_\_\_\_\_ Name of Previous Dentist: \_\_\_\_\_

For what service? \_\_\_\_\_ Child's attitude to dentistry \_\_\_\_\_

Is fluoride taken in any form? \_\_\_Yes \_\_\_No      Is your child currently in pain? \_\_\_Yes \_\_\_No

Any mouth habits- thumbsucking, nail biting, mouth breathing, pacifier, nursing bottle, etc.: \_\_\_\_\_

Any injuries to mouth, teeth or head \_\_\_Yes \_\_\_No      Any unusual speech habits \_\_\_Yes \_\_\_No

Your child's current dental health is: \_\_\_Good \_\_\_Fair \_\_\_Poor

Has your child had dental care instructions? \_\_\_\_\_ How many times a week do they floss? \_\_\_\_\_

How many times a day does your child brush? \_\_\_\_\_ Do you assist? \_\_\_Yes \_\_\_No

Do you use a \_\_\_Hard \_\_\_Medium \_\_\_Soft brush

## ACCOUNT INFORMATION

Person ultimately responsible for account

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Billing Address \_\_\_\_\_ SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_

## DENTAL INSURANCE

Primary Dental Insurance Carrier: \_\_\_\_\_

Insurance Co.

Address: \_\_\_\_\_

Insurance Co. Phone #:\_(\_\_\_\_\_) \_\_\_\_\_

Group # (Plan or Local #): \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's BirthDate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security #: \_\_\_\_\_

## AUTHORIZATION FOR TREATMENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my medical status for my child. *I authorize the dental staff to perform any necessary dental services that my child needs during diagnosis and treatment with my informed consent.*

Signature \_\_\_\_\_ Date \_\_\_\_\_