

CHILD HEALTH HISTORY & REGISTRATION

TODAY'S DATE _____

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

RESIDENCE Street _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ City _____ State _____ Zip _____

PHONE _____ Soc. Sec. # _____

Who May We Thank for Referring You to our Office? _____

RESPONSIBLE PARTY / PARENT/GUARDIAN	OTHER PARENT / GUARDIAN	EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.
NAME _____	NAME _____	NAME _____
ADDRESS _____	ADDRESS _____	RELATIONSHIP _____
EMPLOYER _____	EMPLOYER _____	ADDRESS _____
NO. YEARS EMPLOYED _____	NO. YEARS EMPLOYED _____	CITY, STATE _____
OCCUPATION _____	OCCUPATION _____	PHONE (H) _____
SOC. SEC. # _____	SOC. SEC. # _____	PHONE (W) _____
PHONE (H) _____	PHONE (H) _____	
PHONE (W) _____	PHONE (W) _____	
BIRTHDATE _____	BIRTHDATE _____	

DENTAL INSURANCE INFORMATION (Primary Carrier)	DENTAL INSURANCE INFORMATION (Secondary Carrier)
Insured's Name _____	Insured's Name _____
Insurance Co. _____	Insurance Co. _____
Insurance Co. Address _____	Insurance Co. Address _____
Insured's Employer _____	Insured's Employer _____
Insured's Soc. Sec. # _____	Insured's Soc. Sec. # _____
Group# _____ B. Date _____	Group# _____ B. Date _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

"MEDICAL HISTORY"

	YES	NO	
Does your child have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>	DOES HE./SHE HAVE ANY ALLERGIES TO ANY MEDICATIONS? (circle) Yes No If Yes, please list:
Is he/she under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>	
If So, For What?			
What MEDICATIONS is your child currently taking?			Is there any other Medical information that you feel we should know about?
Is your child PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>	FAMILY PHYSICIAN _____
Does he/she SMOKE or CHEW TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>	Phone No. _____

CIRCLE ANY OF THE FOLLOWING WHICH YOUR CHILD HAS HAD, OR PRESENTLY HAS:

- | | | | |
|-------------------------------|----------------------------------|---------------------------------|---------------------|
| Heart Disease or Attack | Surgery within last 2 years | Sores | Hay Fever |
| Angina Pectoris | Stroke | Epilepsy of Seizures | Sinus Trouble |
| High Blood Pressure | Kidney Trouble | Nervousness | Allergies or Hives |
| Heart Murmur | Ulcers | Psychiatric Treatment | Diabetes |
| Rheumatic Fever | A.I.D.S./A.R.C./HIV Pos. | Glaucoma | Thyroid Disease |
| Congenital Heart Disease | Hepatitis A (infectious) | Chemotherapy (Cancer, Leukemia) | Radiation Treatment |
| Mitral Valve Prolapse | Hepatitis B (serum) | Venereal Disease | Arthritis |
| Artificial Heart Valve | Liver Disease | (Syphilis, Gonorrhea, etc.) | Cortisone Medicine |
| Heart Pacemaker | Blood Transfusion | Bruises Easily | Pain in Jaw Joints |
| Heart Surgery | Drug Addiction | Emphysema | Alcoholism |
| Artificial Joints (Hip, Knee) | Hemophilia (Bleeding Problems) | Tuberculosis (TB) | Cosmetic Surgery |
| Anemia | Fever Blisters/Canker Sores/Cold | Asthma | Latex Allergy |

"DENTAL HISTORY"

HOW LONG SINCE your child has seen a Dentist?				Yes No	
Last COMPLETE Dental Exam, Date:		Does your child have HEADACHES, EARACHES, or NECK PAINS?		<input type="checkbox"/>	<input type="checkbox"/>
Last FULL MOUTH X-RAYS, DATE: (16 small Films or Panoramic)		Has your child worn BRACES on their teeth? (ORTHODONTICS)		<input type="checkbox"/>	<input type="checkbox"/>
		Does your child have DISCOLORED teeth that bother you?		<input type="checkbox"/>	<input type="checkbox"/>
		Yes No			
Is your child having PROBLEMS now?		<input type="checkbox"/>	<input type="checkbox"/>	Would you like your child's smile to LOOK BETTER or DIFFERENT?	
If So, WHAT kind?				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
Are you or your child APPREHENSIVE about dental treatment?		<input type="checkbox"/>	<input type="checkbox"/>	Does your child take fluoride supplements?	
DOES your child's gums BLEED, or feel TENDER or IRRITATED?		<input type="checkbox"/>	<input type="checkbox"/>	How would you rate your child's dental health	
				Good	Fair
				Poor	
Are your child's teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		<input type="checkbox"/>	<input type="checkbox"/>	How often does your child brush?	
Is your child aware of GRINDING OR CLENCHING THEIR TEETH?		<input type="checkbox"/>	<input type="checkbox"/>	How often does your child floss?	
Does Your Child:		Name of Previous Dentist: _____			
Suck Thumb/Finger		<input type="checkbox"/>	<input type="checkbox"/>	City: _____ State: _____	
Suck/Bite Lips		<input type="checkbox"/>	<input type="checkbox"/>	What is the reason for this appointment?	
Bite/Chew Nails		<input type="checkbox"/>	<input type="checkbox"/>		
Chew Hard Objects (Pencils, etc.)		<input type="checkbox"/>	<input type="checkbox"/>		
How often do you feel your child should have a dental exam?					
6 months		1 year		per problem	

N.E.W. U.P. DENTAL P.C.

is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

CONSENT

1. I hereby authorized doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs and to be used by the doctor in scientific papers & demonstrations.
2. Upon such diagnosis, I authorized doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received within 60 days after date of service, I understand that a 1-1/2% service charge (18% APR) may be added to my account.

Parent or Responsible Party _____ Relationship to Patient _____

Date _____ Witness _____