



PATIENT REGISTRATION—CHILD

Date \_\_\_\_\_

Child's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent's Name \_\_\_\_\_  
Last First Middle

Who should we contact in case of emergency? \_\_\_\_\_  
Phone Number

How would you like your child's appointment confirmed?  home phone  cell phone \_\_\_\_\_  
 work phone \_\_\_\_\_  e-mail \_\_\_\_\_

Is child covered by dental insurance? \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Name of Dental Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Dental Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Secondary Policy Holder \_\_\_\_\_

Referred By \_\_\_\_\_

Who is financially responsible for child's dental care? \_\_\_\_\_

DENTAL HISTORY

When was the last time your child had their teeth cleaned? \_\_\_\_\_

Has your child complained about dental problems?..... Yes  No

Has your child had any unhappy dental experiences?..... Yes  No

Has your child had any injuries to the mouth, teeth, or head?..... Yes  No

Does your child have any mouth habits, i.e. thumbsucking, nail biting, mouth breathing, etc.?  Yes  No

Does your child clench or grind teeth during the day or night?..... Yes  No

Does your child have any unusual speech habits? ..... Yes  No

Does your child brush his/her teeth daily?..... Yes  No

What is the child's attitude towards dentistry? \_\_\_\_\_

Please add anything you feel is important for the doctor to know \_\_\_\_\_

# MEDICAL HISTORY—CHILD

Child's general health (please check)    Excellent     Fair     Poor

Name and address of physician \_\_\_\_\_

Child's last complete physical \_\_\_\_\_ Is your child under care of a physician now?  Yes  No

Is your child receiving any medication?  Yes     No

If so, please list? \_\_\_\_\_

Does your child have any of the following:

Heart Murmur .....  Yes     No

Mitral Valve Prolapse .....  Yes     No

Rheumatic Fever .....  Yes     No

Heart Problems .....  Yes     No

High Blood Pressure .....  Yes     No

Circulatory Problems .....  Yes     No

Nervous Problems .....  Yes     No

Excessive Bleeding .....  Yes     No

Allergies to Anesthetics .....  Yes     No

If So, What? \_\_\_\_\_

Allergies to Medicines/ Drugs .....  Yes     No

If So, What? \_\_\_\_\_

Allergies to \_\_\_\_\_

Fainting.....  Yes     No

Epilepsy .....  Yes     No

AIDS .....  Yes     No

Anemia.....  Yes     No

Kidney or Liver Problems .....  Yes     No

Asthma or Hay Fever .....  Yes     No

Diabetes.....  Yes     No

Hepatitis .....  Yes     No

Malignancies .....  Yes     No

Small Pox .....  Yes     No

Brain Injury.....  Yes     No

Scarlet Fever.....  Yes     No

Sinus Problems .....  Yes     No

Other \_\_\_\_\_

Is there any other conditions or problems that you think we should know about? \_\_\_\_\_

**Appointments: A charge will be made for missed appointments or cancellations with less than 24-hours notice. This time is being reserved specifically for you.**

I, the undersigned, have answered the above questions as carefully as possible and understood each question being asked.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Referred By: \_\_\_\_\_