



Evergreen Dental Group,
 Donald G. Sharp, D.D.S.
 Jeffrey J. Sprout, D.D.S.
 Beverly C. Keeler, D.D.S.

31226 Lewis Ridge Rd. • Evergreen, CO 80439
 (303) 674-5566

CHILD'S REGISTRATION & HISTORY

Date _____

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Name of minor/child _____
Last Name First Name Middle Initial

Sex ___ M ___ F Age ___ Birthdate _____ Nickname _____

Home address _____
Street City State Zip

Mailing address _____
Street City State Zip

Person financially responsible _____ Home phone _____ Work Phone _____

Whom may we thank for referring you? _____

Mother/Guardian

Father/Guardian

Name _____
 Occupation _____
 Business Name _____
 Business Location _____
 Business Phone _____

Name _____
 Occupation _____
 Business Name _____
 Business Location _____
 Business Phone _____

If different from patient: _____

If different from patient: _____

Home address _____
Street or PO Box

city state zip

Home address _____
Street or PO Box

city state zip

Home phone _____

Home phone _____

Is patient covered by dental insurance? no () yes ()

INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Insured's Name _____
 Relationship to patient _____
 Social Security # _____
 Date of Birth _____
 Employer _____

Insured's Name _____
 Relationship to patient _____
 Social Security # _____
 Date of Birth _____
 Employer _____

Insurance Co. _____

Insurance Co. _____

Street or PO Box

city, state zip

Street or PO Box

city, state zip

Group # _____

Group # _____

CERTIFICATION AND CONSENT FOR TREATMENT OF A MINOR

I certify that the above information is correct. I hereby authorize Evergreen Dental Group, PC to perform the examination (including any necessary x-rays). In addition, I authorize all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until canceled by either party.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Signature _____ Relationship to child _____ Date _____

DENTAL HISTORY

Date of last dental visit: _____ Purpose of last visit: _____

Does your child:

Complain about dental problems? Y N
Brush daily? Y N
Floss daily? Y N
Take fluoride in any form? Y N

Has your child:

Had local anesthetic? Y N
Had any injuries to mouth, teeth, head? Y N
Had any unhappy dental experiences? Y N
Had any bad habits, such as thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? Y N

MEDICAL HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

*If you answer "yes" to any of the following questions, please provide a brief explanation in the space provided:

Is your child under the care of a physician now? Y N _____

Is your child receiving any medication or drugs? Y N _____

Has your child ever been hospitalized? Y N _____

Does your child bleed excessively when cut? Y N _____

Has your child ever had any unfavorable reactions to any medications or drugs? Y N _____

Is your child allergic to vinyl, metals, or acrylics? Y N

Is your child allergic to latex (balloons, rubber products)? Y N

To what medications or drugs is your child allergic? _____

Please list any other allergies: _____

Has your child had any history or difficulty with the following?

Y N heart	Y N HIV	Y N mumps	Y N epilepsy	Y N mononucleosis
Y N lungs	Y N hearing	Y N measles	Y N chicken pox	Y N cerebral palsy
Y N liver	Y N asthma	Y N thyroid	Y N convulsions	Y N rheumatic fever
Y N kidney	Y N fainting	Y N anemia	Y N tuberculosis	Y N speech problems
Y N bladder	Y N diabetes	Y N hepatitis	Y N malignancy	Y N chronic sinusitis
Y N heart murmur/heart defect			Y N cleft lip or palate	

Other Please explain: _____

Please identify any dental or medical problem of special concern or provide any other information that you think might be important in the care of your child. _____

I certify that the above information is true and correct to the best of my knowledge.

Signature _____ Relationship to child _____ Date _____