

# CHILD REGISTRATION

Today's Date: \_\_\_\_\_  
Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Birthdate \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Child's Home # \_\_\_\_\_ SS# \_\_\_\_\_  
Childs Home Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## WHO IS ACCOMPANYING THE CHILD TODAY?

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Do you have legal custody of this child? \_\_\_\_\_  
Whom may we **Thank** for referring you \_\_\_\_\_  
Other family members seen by us \_\_\_\_\_  
Previous/Present Dentist \_\_\_\_\_ Last visit date \_\_\_\_\_

## PARENT'S INFORMATION

Parent's Marital Status: Married Divorced Single Separated Widowed  
Child resides with \_\_\_\_\_

## MOTHER'S INFORMATION

Mother's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_  
Home# \_\_\_\_\_ Work # \_\_\_\_\_  
Employer \_\_\_\_\_  
SS# \_\_\_\_\_ DL# \_\_\_\_\_

## FATHER'S INFORMATION

Father's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_  
Employer \_\_\_\_\_  
SS# \_\_\_\_\_ DL# \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Name \_\_\_\_\_ Relation \_\_\_\_\_  
Billing Address \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_  
DL# \_\_\_\_\_ SS# \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Insurance Co \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_  
Phone # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_

Is this the child's first visit to the dentist? \_\_\_\_\_  
Has the child had a cleaning and comprehensive exam before? \_\_\_\_\_  
Has the child ever had a serious/difficult problem associated with previous dental work? \_\_\_\_\_  
If yes please explain \_\_\_\_\_

Is the child having any problems with his/her teeth? \_\_\_\_\_  
Is the child's water fluoridated? \_\_\_\_\_  
Is the child taking fluoridated supplements? \_\_\_\_\_  
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? \_\_\_\_\_  
Does the Child brush his/her teeth daily? \_\_\_\_\_ How many times daily? \_\_\_\_\_  
Floss his/her teeth daily? \_\_\_\_\_

**Does the child have the following habits?**

Lip sucking/biting? \_\_\_\_\_  
Nail Biting \_\_\_\_\_  
Nursing Bottle Habits \_\_\_\_\_  
Thumb/Finger Sucking \_\_\_\_\_

Child's Physician: \_\_\_\_\_  
Phone # \_\_\_\_\_ Last Visit Date \_\_\_\_\_  
Is the child currently under the care of a physician? \_\_\_\_\_  
Describe the child's current health \_\_\_\_\_

**I understand that the information that I have given is correct to the best of my knowledge, that is will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.**

\_\_\_\_\_  
Signature of parent or guardian Date

**The Parent or Guardian who accompanies the child is responsible for payment at the time of service.**

**CHRISTOPHER L. BARNES, D.D.S.**  
**670 W ARAPAHO RD., SUITE 1**  
**RICHARDSON, TX 75080**  
**972.783.0990**

**MEDICAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you have a personal physician?  Yes  No Date of last checkup \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_

Are you currently under the care of a physician?  Yes  No Please explain \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor

Do you smoke or use tobacco in any other form?  Yes  No

Have you had any metal rods, pins or implants?  Yes  No

Please explain \_\_\_\_\_

**\*\*PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH QUESTION.**

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Artificial Bones/Joints	Y	N	Hearing Loss
Y	N	Artificial Heart valves	Y	N	Intestinal Problems
Y	N	Asthma or Hay Fever	Y	N	Kidney Problems
Y	N	Anemia/Bulimia	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Neurological Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Family History of Diabetes	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy or Seizures	Y	N	Rheumatic Fever/ Heart Disease
Y	N	Fainting Spells	Y	N	Shunts/Stints
Y	N	Frequent Headaches	Y	N	Stroke
Y	N	Glaucoma	Y	N	Shingles
Y	N	Heart Murmur	Y	N	Sinus Problems
Y	N	Heart Surgery	Y	N	Sexually Transmitted Disease
Y	N	Hemophilia	Y	N	Thyroid Problems
Y	N	Hepatitis or Liver Disease	Y	N	Tuberculosis
Y	N	Heart Disease Detected at Birth	Y	N	Ulcers

Please list any serious medical condition(s) \_\_\_\_\_

Are you ALLERGIC to any of the following?

Y	N	Aspirin	Y	N	Erythromycin
Y	N	Codeine	Y	N	Latex
Y	N	Tetracycline	Y	N	Dental Anesthetics
Y	N	Penicillin	Y	N	Sulfa Drugs

Other Allergies \_\_\_\_\_

Are you taking any of the following?

Y	N	Antibiotics	Y	N	Tranquilizers
Y	N	Blood Thinners	Y	N	Insulin/other diabetes drugs
Y	N	Blood Pressure Medication	Y	N	Recreational Drugs
Y	N	Thyroid Medication	Y	N	Digitalis/other heart medication
Y	N	Cortisone/Steroids	Y	N	Nitroglycerin
Y	N	Antihistamines/Allergy Medications	Y	N	Aspirin

Please list name of medication and dosage

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

**For Women**

Are you taking birth control pills?    Yes    No  
Are you pregnant?                            Yes    No  
Are you nursing?                              Yes    No

**EMERGENCY CONTACT NEIGHBOR OR RELATIVE NOT LIVING WITH YOU**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home# \_\_\_\_\_ Work \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell \_\_\_\_\_

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 of confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

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

Name of person completing form (if different from the patient) and relation to patient: \_\_\_\_\_