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CHILD REGISTRATION FORM

NAME ____ DATE OF BIRTH _____/_____/_____
(First) (Middle) (Last) (Nick Name)

SOC. SEC. # ____________

HOME ADDRESS ____________________________ HOME PHONE ____________

CITY/STATE ____________________________ ZIP CODE ____________

SCHOOL ____________________________ GRADE LEVEL ____________

FAVORITE SPORT ____________________ FAVORITE HOBBY ____________________

FATHER ____________________________ HOME PHONE ____________

EMPLOYER ____________________________ BUSINESS PHONE ____________

MOTHER ____________________________ HOME PHONE ____________

EMPLOYER ____________________________ BUSINESS PHONE ____________

PERSON RESPONSIBLE FOR PAYMENT ____________________ RELATION ____________

DENTAL INSURANCE

INSURED'S NAME ____________________ DATE OF BIRTH _____/_____/_____ S.S. # ____________

INSURANCE COMPANY ____________________ GROUP NAME / GROUP # ____________

ADDITIONAL DENTAL INSURANCE

INSURED'S NAME ____________________ DATE OF BIRTH _____/_____/_____ S.S. # ____________

INSURANCE COMPANY ____________________ GROUP NAME / GROUP # ____________

DENTAL QUESTIONS:

PREVIOUS DENTIST ____________ ADDRESS/PHONE ____________ DATE OF LAST VISIT ________

LIST YOUR MAIN DENTAL CONCERN(S) ________________________________

Does your child brush daily? YES___ NO___ Do you help? YES___ NO___ Is dental floss used? YES___ NO___

Is any fluoride used? ....YES___ NO___ Are any teeth painful? YES___ NO___ Which ones? ________

Child's attitude to Dentistry ____________________ Any unhappy dental experiences? ____________________

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MEDICAL QUESTIONS:

CURRENT PHYSICIAN ____________________ ADDRESS/PHONE ____________________

Has your child ever been hospitalized? ....YES___ NO___ for ____________________

Is your child being seen by a physician? ....YES___ NO___ for ____________________

Is your child taking any kind of medication? ....YES___ NO___ name of drug(s) ____________________

Is your child allergic to any medication? ....YES___ NO___ name of drug(s) ____________________

Are there any other allergies?: food, animals ....YES___ NO___ what kinds ____________________

Is there any excessive bleeding when cut? ....YES___ NO___

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

AIDS	CANCER TREATMENT	DIABETES	HEART MURMUR	KIDNEY PROBLEMS	ORGAN TRANSPLANT
ANEMIA	CHICKEN POX	EPILEPSY	HEPATITIS	MEASLES	RHEUMATIC FEVER
ASTHMA	PERSISTENT COUGH	JAUNDICE	HERPES	MUMPS	TUBERCULOSIS

List any other illness or medical condition not listed above ________________________________

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SIGNED **(Parent or Guardian)** ________________________________ **Date** ____________