CHILD REGISTRATION FORM

TELL US ABOUT YOUR CHILD

Today's Date: ____________________

Child's Name: ____________________
Last First MI

Nick Name: ____________ Male____ Female ____

Child's Birthdate: ____________ Age ____

Child's Home Phone #: ____________ SSN ____________

Child's Home Address: ____________________

____
City State Zip

Special Interests / Hobbies: ____________________

WHO IS ACCOMPANYING THE CHILD TODAY

Name: ____________ Relation ____________

Do you have legal custody of this child? _____Yes _____No

Who may we thank for referring you? ____________________

Names of other family members seen by us: ____________________

____

Parents Marital Status: _____Single _____Married _____Widowed _____Separated

MOTHER'S INFORMATION

Name: ____________________

Work Phone #: ____________ Ext_____ Home Phone #: ____________

Employer: ____________________

SSN ____________ Cell Phone ____________

FATHER'S INFORMATION

Name: ____________________

Work Phone #: ____________ Ext_____ Home Phone #: ____________

Employer: ____________________

SSN ____________ Cell Phone ____________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____________ Relation ____________

Billing Address: ____________________

____
City State Zip

Work Phone #: ____________ Home Phone #: ____________

Employer: ____________________

SSN ____________ Cell Phone ____________

DENTAL INSURANCE

Insurance Co. Name: ____________________

Group #: ____________________

Insured's Name: ____________________

Insured's Date Of Birth: ____________________

SSN ____________ Employer ____________

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y N Thumb / Finger Sucking
Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing Bottle Habits

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY?

Has the child been to the dentist before? _____Yes _____No

Has the child ever had a serious / difficult problem associated with previous dental work? _____Yes _____NO

Explain: ____________________

Is the child's water fluoridated? _____Yes _____No

Is the child taking fluoride supplements? _____Yes _____No

Does the child brush teeth daily? _____Yes _____No

Please rate the child's oral health _____Good _____Fair _____Poor

Child's physician: ____________________

Phone #: ____________ Date of last visit ____________

Is the child currently under care of a physician? _____Yes _____No

Please list all drugs the child is currently taking: ____________________

____

Please list all drugs that the child is allergic to: ____________________

____

Please list all food allergies of the child: ____________________

____

Does the child need to be premedicated before dental treatment?

Explain: ____________________

DOES THE CHILD HAVE OR HAD ANY OF THE FOLLOWING:

Y	N	Heart Murmur	Y	N	Congenital heart defect
Y	N	Cancer	Y	N	Convulsions / Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV / AIDS	Y	N	Any operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney / Liver problems
Y	N	Hepatitis	Y	N	Handicaps / Disabilities
Y	N	Tuberculosis (TB)	Y	N	ADD
Y	N	Autism	Y	N	ADHD

Please discuss any serious medical problems that the child has had:

____

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 confidence and it is my responsibility to inform this office of any changes in the medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that the child may need during diagnosis and treatment.

X ____________________

FINANCIAL UNDERSTANDING

I hereby agree to be fully responsible for payment of all fees for services performed, including any amounts which are not covered by any dental insurance that I may have. I further agree to pay any collection costs, including, but not limited to reasonable attorney's fees, court costs and/or collection costs, which may arise from non-payment of this account.

Signature ____________________ Date: ____________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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