Pediatric Registration

Tell us about your child

Name: _____ (Last) _____ (First) _____ (Mid)

Nickname: _____ Sex: _____

Child's birthday: __/__/____ Age: _____

School: _____ Grade: _____

Child's home: (___) - ___ - ____ Social security #: ___-___-____

Email address: _____

Home address: _____ APT #: _____

City: _____ State: _____ Zip: _____

Who is accompanying the child today?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

How did you hear about us? _____

Have you visited our website? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

_____

Other family members seen by us:

_____

_____

_____

_____

_____

Previous / Present dentist: _____

Last visit date: __/__/____

Parent's marital status : ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Mother's information: ☐ Step mother ☐ Guardian

Name: _____

Birthday: __/__/____ Social security #: ___-___-____

Telephone work: (___) - ___ - ____ Ext: ____

Telephone home: (___) - ___ - ____

Employer: _____

Father's information : ☐ Step father ☐ Guardian

Name: _____

Birthday: __/__/____ Social security #: ___-___-____

Telephone work: (___) - ___ - ____ Ext: ____

Telephone home: (___) - ___ - ____

Employer: _____

Person responsible for account

Name: _____

Relation: _____

Billing address: _____ APT #: _____

City: _____ State: _____ Zip: _____

Telephone home: (___) - ___ - ____

Driving license #: _____

Employer: _____

Telephone work: (___) - ___ - ____ Ext: ____

Social security #: ___-___-____

Who is responsible for making appointments?

Name: _____

Telephone work: (___) - ___ - ____ Ext: ____

Telephone home: (___) - ___ - ____

Primary insurance Dental coverage? ☐ Yes ☐ No

Insurance co. name: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Phone: (___) - ___ - ____

Group# (Plan, Local or Policy#): _____

Insured's name: _____

Relation: _____

Birthday: __/__/____ Social security #: ___-___-____

Insured's employer: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Secondary insurance Dental coverage? ☐ Yes ☐ No

Insurance co. name: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Phone: (___) - ___ - ____

Group# (Plan, Local or Policy#): _____

Insured's name: _____

Relation: _____

Birthday: __/__/____ Social security #: ___-___-____

Insured's employer: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

Why did you bring your child to the dentist today?

_____

_____

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in this / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Is the child currently under the care of a physician? ☐ Yes ☐ No

Child's physician: _____

Last visited on: __/__/____ Telephone: (___) - ___ - ____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Is your child allergy to Nuts? ☐ Yes ☐ No

Has the child had any traumatic experiences at the dental office? ☐ Yes ☐ No

Does the child have a specific fear about going to the dental office? ☐ Yes ☐ No

Please list all drugs that the child is currently taking:

_____

_____

_____

_____

Please list all drugs / materials that the child is allergic :

_____

_____

_____

_____

Latex? ☐ Yes ☐ No Metals / Nickel? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No

Has the child ever had any of the Following medical problems?

Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Diabetes
☐	☐	ADD / ADHD	☐	☐	Handicaps / Disabilities
☐	☐	Allergies to any drugs	☐	☐	Hearing impairment
☐	☐	Any hospital stays	☐	☐	Heart murmur
☐	☐	Any operations	☐	☐	Hemophilia
☐	☐	Artificial Bones / Joints / Valves	☐	☐	Hepatitis
☐	☐	HIV+ / AIDS	☐	☐	Kidney / Liver problems
☐	☐	Asthma	☐	☐	Rheumatic / Scarlet fever
☐	☐	Cancer	☐	☐	Sickle cell disease / traits
☐	☐	Congenital heart defect	☐	☐	Tuberculosis (TB)
☐	☐	Convulsions / Epilepsy			

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

_____

_____

_____

_____

Does/Did the child have any of the following habits?

☐ Yes ☐ No Lip sucking / Biting ☐ Yes ☐ No Nail biting

☐ Yes ☐ No Nursing bottle habits ☐ Yes ☐ No Thumb / Finger sucking

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

Neighbor or relative not living with you.

Name: _____

Phone: (___) - ___ - ____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____

I Agree and if deemed advisable, I grant permission for our physician to be contacted for details and advice. For evaluation or teaching purposes I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility

_____ _____

Signature of parent or guardian Date

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments:_____

_____

_____

_____

_____