Child / Minor Registration

Today's Date:________________

Child's name: ________________ Birthdate: ________________ Nickname: ________________

School: ____________________ Grade: _____

Who is accompanying the child today?

Name: ____________________ Relation: _______________ Legal custody of child? ________

Who may we thank for referring you? ____

Previous dentist: ____________________________ Date of last visit: ______________________

Person Responsible for Account

Name: _______________________ Relation: __________

Billing Address: ______________________________ City: ______________ State/zip: ______

Employer: _________________________ SS# _________________ DL# ______________

Home phone: ____________________ Work phone: ____________________ ext. _______

Dental Insurance Information

Insurance Company Name: ____

Ins. Co. Address: ____

Group # _____________________________________ Policy# ____________________

Insured's Name: ___________________________ Relationship to patient: ________________

Insured's Birthday: _______________ SS# ________________ Employer: ______________

Physician Information

Name of child's physician:_______________________ Phone# __________________________

Date of last physical: _________________________ ***(Over please!)***

-Medical / Dental History-

1. Has the child ever had a serious / difficult problem associated with dental work? Y N
2. Is the child's water fluoridated? Y N
3. Does the child brush their teeth daily? Y N
4. Is the child currently under the care of a physician? Y N
5. Please indicate the child's current physical health: Good Fair Poor
6. List all drugs the child is currently taking: ____________________
7. Please list any allergies: ____________________
8. Purpose for today's dental visit: ____________________

Has your child had any of the following medical problems?

Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV / AIDS
Y N Asthma
Y N Hepatitis
Y N Tuberculosis (TB)
Y N Heart Defects
Y N Convulsions / Epilepsy
Y N Abnormal Bleeding
Y N Any Operations or Hospital Stays
Y N Handicaps or Disabilities
Y N Allergies to any Drugs

Please indicate any serious medical problems that the child has had: ____________________

Y N Thumb / Finger Sucking
Y N Lip sucking / Biting
Y N Nail Biting
Y N Gum chewing

I understand that the information that I have given is correct to the best of my knowledge, that it 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. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature: ____________________ *Date:* __________