CHILD'S REGISTRATION AND HISTORY

Date

Child's name | Nickname | Age | Birth date

Residence address | City | State | Zip

School | Address | Grade

Father's name | Mother's name

Father employed by | How long | Home phone | Bus. phone

Mother employed by | How long | Home phone | Bus. phone

Person financially responsible (if other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | Driver license no. | State

Mother's Social Security number | Driver license no. | State

Father's birth date | Mother's birth date

Credit card name | No. | Expiration date

When dental insurance coverage name of carrier

Secondary insurance coverage, if any

Whom may we thank for referring you

What is child's favorite: sport | toy | hobby | person | fictional character

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

	Yes	No
Has child complained about dental problems	☐	☐
Any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.	☐	☐
Any unusual speech habits	☐	☐
Any lost teeth	☐	☐
Have missing teeth been replaced	☐	☐
Orthodontic appliances worn now or ever been	☐	☐

	Yes	No
Does your child brush teeth daily	☐	☐
Do you assist child with tooth brushing	☐	☐
How often		
Is dental floss used	☐	☐
How often		
Are disclosing tablets used	☐	☐
Is fluoride taken in any form	☐	☐
Do you desire complete dental service for the child	☐	☐

Child's attitude to dentistry _____

Summary (for doctor's use) _____

(over)

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No
Is child under care of physician now	❑	❑
Is child receiving any medication or drugs		
Is there any excessive bleeding when cut	❑	❑
Has child ever been hospitalized	❑	❑
	❑	❑
Has child ever had surgery	❑	❑
Is there any allergy to penicillin or other drugs	❑	❑
Are there other allergies: food-pollen-animals-dust-other	❑	❑

	Yes	No
Does child have good physical coordination	❑	❑
Are there any emotional problems	❑	❑

Summary (for doctor's use) _____

Has child any history of or difficulty with any of the following: Check only if yes.

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Trouble/Disease	❑	❑	Bruise Easily	❑	❑	Emphysema	❑	❑	Yellow Jaundice	❑	❑	Cold Sores
❑	❑	Heart Murmur	❑	❑	Anemia	❑	❑	Tuberculosis	❑	❑	Kidney Problems	❑	❑	Fever Blisters
❑	❑	Irregular Heart Beat	❑	❑	Excessive Bleeding	❑	❑	Cancer	❑	❑	Renal Dialysis	❑	❑	Herpes
❑	❑	Angina/Chest Pain	❑	❑	Sickle Cell Disease	❑	❑	X-Ray Treatments (Radiation)	❑	❑	Thyroid Disease	❑	❑	Stroke
❑	❑	Heart Attack/Failure	❑	❑	Hemophillia (Bleeding Problem)	❑	❑	Chemotherapy	❑	❑	Parathyroid Disease	❑	❑	Convulsions
❑	❑	Congenital Heart Disorder	❑	❑	Leukemia	❑	❑	Stomach/Intestinal Disease	❑	❑	Arthritis/Gout	❑	❑	Epilepsy or Seizures
❑	❑	Mitral Valve Prolapse	❑	❑	Recent Blood Transfusion	❑	❑	Ulcers	❑	❑	Rheumatism	❑	❑	Fainting or Dizziness
❑	❑	Scarlet Fever	❑	❑	Swelling of Limbs	❑	❑	Recent Weight Loss	❑	❑	Pain in Jaw Joints	❑	❑	Glaucoma
❑	❑	Rheumatic Fever	❑	❑	Lung Disease	❑	❑	Frequent Diarrhea	❑	❑	Cortisone Medicine	❑	❑	Tumors or Growths
❑	❑	Artificial Heart Valve	❑	❑	Breathing Problem	❑	❑	Diabetes	❑	❑	Artificial Joint	❑	❑	Nervousness
❑	❑	Heart Pace Maker	❑	❑	Shortness of Breath	❑	❑	Excessive Thirst	❑	❑	Venereal Disease	❑	❑	Psychiatric Care
❑	❑	Heart Surgery	❑	❑	Frequent Cough	❑	❑	Hypoglycemia	❑	❑	AIDS	❑	❑	Alzheimer's Disease
❑	❑	High Blood Pressure	❑	❑	Hay Fever	❑	❑	Liver Disease	❑	❑	HIV Positive	❑	❑	Allergies (Medicines)
❑	❑	Low Blood Pressure	❑	❑	Sinus Trouble	❑	❑	Hepatitis A (Infectious)	❑	❑	Genital Herpes	❑	❑	Allergies (Pollen/Dust)
❑	❑	Blood Disease	❑	❑	Asthma	❑	❑	Hepatitis B or C	❑	❑	Drug Addiction	❑	❑	Hives or Rash

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Address _____

City/State/Zip _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third payors and/or other health professionals.

_____

❑ Adult Patient ❑ Father (Or Husband) ❑ Mother (Or Wife) ❑ Guardian

_____

Date State Driver's License #

PERSON TO CONTACT IN CASE OF EMERGENCY

Please Check One

❑ Patient ❑ Father (or Husband)
❑ Guardian ❑ Mother (Or Wife)

METHOD OF PAYMENT

Responsible party currently has an account with this office

❑ YES ❑ NO

❑ Payment in full at each appointment (cash or personal check)

❑ Payment in full at each appointment (❑ VISA ❑ MC)
Card # _____ Exp. Date _____

❑ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If do not pay the entire new balance within 25 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00 for a balance under $200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.