CHILD REGISTRATION AND HISTORY

Child's Legal Name: ______________________________ Birth date: ______________

Social Security Number: ______________________________ Age: _______ Grade: ______________

Address: ______________________________ Home Phone: ______________

City: ______________________________ State: _______ Zip: ______________

( )**Male** ( )**Female**

( )**Parent** ( )**Guardian**

Fathers Name: ______________________________ Social Security #: ______________

Address (if different than above): ______________________________ Home Phone: ______________

City: ______________________________ State: _______ Zip: ______________

Employed By: ______________________________ Work Phone: __________ Ext. _______

Mothers Name: ______________________________ Social Security #: ______________

Address (if different than above): ______________________________ Home Phone: ______________

City: ______________________________ State: _______ Zip: ______________

Employed By: ______________________________ Work Phone: __________ Ext. _______

Whom may we thank for referring you? ______________________________

Primary Dental Insurance Company: ______________________________ Phone: ______________

Policy Holders name: ______________________ Employer: ______________________

Policy Holders ID#: ______________________ Group #: ______________________

Policy Holders Date of Birth: ______________________ Policy Holders SS#: ______________________

Secondary Dental Insurance Co. Name: ______________________________ Phone: ______________

Policy Holders name: ______________________ Employer: ______________________

Policy Holders ID#: ______________________ Group #: ______________________

Policy Holders Date of Birth: ______________________ Policy Holders SS#: ______________________

Parent/Guardian Signature ______________________________ Date: ______________

I have been offered a copy of the HIPAA privacy practices.

DENTAL HISTORY

Date of last visit to a dentist ______________________

For what service ______________________

______________________ **Yes No**

Has child complained about dental problems __________ ( ) ( )

____

Any mouth habits – thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. __________ ( ) ( )

____

Yes No

Does your child brush teeth daily ________ ( ) ( )

Do you assist child with tooth brushing ____ ( ) ( )

Is dental floss used ______________ ( ) ( )

Any unhappy dental experiences ________ ( ) ( )

____

Any injuries to mouth - teeth - head ______ ( ) ( )

____

HEALTH HISTORY

Childs physician ____

Date of last physical examination____________________Results____________________

	Yes	No		Yes	No
Is child under care of physician now____________	( )	( )	Does child have good physical coordination__________	( )	( )
____________			____________		
Is child receiving any medication or drug__________	( )	( )	Are there any emotional problems __________	( )	( )
____________			____________		
Is there any excessive bleeding when cut __________	( )	( )	Summary (for doctors use) __________		
____________			____________		
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, other ________	( )	( )	____________		
____________			____________		

Has child any history of or difficulty with any of the following:

__Anemia	__Chronic Sinus	__Hearing	__Mastoid	__Thyroid
__Asthma	__Convulsions	__Heart	__Measles	__Tuberculosis
__Bladder	__Diabetes	__Kidney	__Mononucleosis	__Other
__Cerebral Palsy	__Epilepsy	__Liver	__Mumps	
__Chicken pox	__Fainting	__Malignancies	__Rheumatic fever	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

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May we request release of your child's medical records for our reference____________________ Yes No

This information was discussed with and given by ____________________________

Relation to child ____

Summary: (for doctor's use)