CHILD'S REGISTRATION AND HISTORY

Date _____

Child's Name _____ Nickname _____ Age _____ Birthdate _____

Residence Address _____ City _____ State _____ Zip _____

School _____ Address _____ Grade _____

Father's Name _____ Mother's Name _____

Father Employed By _____ PHONE: Cell _____ Home _____ Bsns _____

Mother Employed By_____ PHONE: Cell _____ Home _____ Bsns _____

Person financially responsible (if other than parent) _____ Relationship to Child _____

Address _____ City _____ State _____ Zip _____ Phone _____

Father's Social Security # _____ Birthdate _____Email _____

Mother's Social Security # _____ Birthdate _____Email _____

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 _____	☐	☐
_____		
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 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-animal-dust-other_____	☐	☐

	Yes	No
Does child have good physical coordination _____	☐	☐
Are there any emotional problems_____	☐	☐

Summary (for doctor's use) _____

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

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble/Disease	☐	☐	Sickle Cell Disease	☐	☐	Liver Disease
☐	☐	Irregular Heart Beat	☐	☐	Hemophillia (Bleeding Problem)	☐	☐	Hepatitis A (Infectious)
☐	☐	Angina/Chest Pain	☐	☐	Leukemia	☐	☐	Hepatitis B or C
☐	☐	Heart Attack/Failure	☐	☐	Lung Disease	☐	☐	Kidney Problems
☐	☐	Congenial Heart Disorder	☐	☐	Breathing Problem	☐	☐	Renal Dialysis
☐	☐	Artificial Heart Valve	☐	☐	Sinus Trouble	☐	☐	Thyroid Disease
☐	☐	Heart Pace Maker	☐	☐	Asthma	☐	☐	Artificial Joint
☐	☐	Heart Surgery	☐	☐	Tuberculosis	☐	☐	HIV Positive
☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐	Drug Addiction
☐	☐	Low Blood Pressure	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Stroke
☐	☐	Blood Disease	☐	☐	Chemotherapy	☐	☐	Epilepsy or Seizures
☐	☐	Bruise Easily	☐	☐	Stomach/Intestinal Disease	☐	☐	Fainting or Dizziness
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Tumors or Growths

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 #

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 ☐ MCard)
Card # _____ Exp. Date _____

☐ I wish to discuss the Dental Office's Financial Policy.

SERVICE CHARGE

If you 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.

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