

CHILD REGISTRATION

GENERAL INFORMATION

Address _____ Phone _____
City _____ State _____ Zip _____
Father's Name _____ Date of Birth _____ SSN# _____
Employer _____ Occupation _____ Phone _____
Mother's Name _____ Date of Birth _____ SSN# _____
Employer _____ Occupation _____ Phone _____
With whom does the child live? _____

CHILD'S HISTORY

Child's Full Name _____ Preferred Name _____
Age _____ Date of Birth _____ Attends what School? _____ Grade _____
Brothers and Sisters (include ages) _____
Whom may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance _____ Group# _____
Billing Address _____ City _____ State _____ Zip _____
Telephone (____) _____ Relationship _____ Date of Birth _____
SSN# _____ Employer _____ Phone _____
Secondary Insurance _____ Group# _____
Billing Address _____ City _____ State _____ Zip _____
Telephone (____) _____ Relationship _____ Date of Birth _____
SSN# _____ Employer _____ Phone _____

Since my child is a minor, I as parent or guardian, give my consent and permission to Dr. Smith and/or Dr. Roman to provide my child with services which may include: dental exam, local anesthetics, x-rays, medications, and other professionally accepted techniques that Dr. Smith and/or Dr. Roman may deem necessary for treatment of my child. I will be responsible for cost of this care regardless of insurance coverage and for any costs of collection including attorney's fees and court costs. Accounts due over thirty days are subject to a \$5.00 per month accounting fee.

Date _____ Signature _____

MEDICAL HISTORY

1. Has your child ever experienced the following?
- a. Seizures, loss of consciousness, fainting? Yes No
 - b. Heart disease, Rheumatic fever, prolonged bleeding? Yes No
 - c. Disease of the blood, blood transfusions, AIDS/HIV? Yes No
 - d. Shortness of breath, bronchitis, pneumonia? Yes No
 - e. Chronic lung disease, asthma? Yes No
 - f. Liver disease, jaundice, hepatitis? Yes No
 - g. Diabetes of glandular problems? Yes No
 - h. Speech, hearing or vision problem? Yes No
 - i. Psychological problems, depression, drug/alcohol abuses, ADD, ADHD? Yes No
 - j. Allergies or unfavorable reaction to ANY medication such as penicillin, aspirin, or local anesthetic? Yes No
- LIST: _____
- k. Other medical conditions? LIST: _____ Yes No
2. What medications is your child taking at this time? LIST: _____
3. Has your child ever had a serious illness or operation? LIST: _____ Yes No
4. List child's hospitalizations: _____
5. Has your child had a physical exam within the last year? Yes No
6. Are child's immunizations (including tetanus) current? Yes No
7. Name of child's physician or pediatrician: _____

DENTAL HISTORY

- 1. Is this your child's first visit to the dentist? Yes No
- 2. Has your child had a toothache recently? Yes No
- 3. Has your child ever chipped or damaged any teeth? Yes No
- 4. Does your child have a history of oral habits such as thumb sucking? Yes No
- 5. Has your child had a negative dental or medical experience? Yes No
- 6. Has your child ever slept with a bottle or does he/she now sleep with a bottle? Yes No