Pediatric Registration and Health History Form

ABOUT YOUR CHILD

_____
Child's Name

____ YRS ____ MOS □ **M** □ **F** _______________
Age Date of Birth

_____
School

REASON FOR VISIT:
Exam Emergency Treatment Other

How did you hear about us?
Google Facebook Internet Insurance
Other: _____

DENTAL INSURANCE

PRIMARY

Relationship to child: □ Mom □ Dad □ Self (Medicaid)
Insurance Company Name: _____
Policy Holder's Name: _____
Policy Holder's DOB: _______________
ID Number: _____
Group Number: _____

SECONDARY

Relationship to child: □ Mom □ Dad □ Guardian
Insurance Company Name: _____
Policy Holder's Name: _____
Policy Holder's DOB: _______________
ID Number: _____
Group Number: _____

CONTACT INFORMATION

Child lives with: □ **Mom** □ **Dad** □ **Guardian**

Parent one: □ Mom □ Dad □ Guardian

_____
Name

_______________ _____- _____ - _____
Date of Birth **Social Security Number**

_____
Address

_____ _____ _____
City State Zipcode

(_____) _____ □ **H** □ **C** □ **W**
Best Contact Number

_____
Email Address

Parent two: □ Mom □ Dad □ Guardian

_____
Name

_______________ _____- _____ - _____
Date of Birth **Social Security Number**

_____
Address

_____ _____ _____
City State Zipcode

(_____) _____ □ **H** □ **C** □ **W**
Best Contact Number

_____
Email Address

ACKNOWLEDGMENT AND AUTHORIZATION

The permission of a parent or guardian is necessary for dental treatment of a minor. I give the doctor(s) permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. I also understand that I am responsible for all charges incurred by myself or my family regardless of insurance coverage and that **PAYMENT IS DUE, IN FULL, AT THE TIME SERVICES ARE RENDERED.**

_____
Signature Relationship to Child Date

Medical Questionnaire and Dental History Form

DENTAL HISTORY

Is this your child's first dental visit? □ Yes □ No

_____

Previous Dentist City

Date of last visit _______________

Were dental xrays taken? □ Yes □ No

Do any of the following apply to your child?

Breast feeding	□ Yes	□ No
Sleeping with a bottle	□ Yes	□ No
Sippy cup use	□ Yes	□ No
Finger/ thumb sucking	□ Yes	□ No
Pacifier use	□ Yes	□ No
Frequent snacking	□ Yes	□ No
Dental grinding/ clenching	□ Yes	□ No

Have previous dental visits been positive or negative?

□ Positive □ Negative (if negative please explain)

_____

_____

MEDICAL HISTORY

____

Date of last physical exam

_____

Physician Name or Practice Name

Has your child ever been hospitalized for surgery?

□ Yes □ No (If yes, explain why)

_____

_____

Is your child presently taking any medications?

□ Yes □ No (If yes, please list all medications below)

_____

_____

_____

Does your child have any allergies to medications, food, latex or other? □ Yes □ No (If yes, please list)

_____

_____

MEDICAL HISTORY CONTINUED

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Abnormal bleeding	□ **Yes**	□ **No**
Blood disorders	□ **Yes**	□ **No**
Sickle cell disease	□ **Yes**	□ **No**
Operations	□ **Yes**	□ **No**
Hospital stay	□ **Yes**	□ **No**
Cancer	□ **Yes**	□ **No**
Hepatitis	□ **Yes**	□ **No**
Epilepsy	□ **Yes**	□ **No**
Pregnant	□ **Yes**	□ **No**
Latex Allergy	□ **Yes**	□ **No**
Allergies to drugs	□ **Yes**	□ **No**
Food Allergies	□ **Yes**	□ **No**
Heart Disease	□ **Yes**	□ **No**
HIV+/ AIDS	□ **Yes**	□ **No**
Rheumatic/ Scarlet Fever	□ **Yes**	□ **No**
Asthma	□ **Yes**	□ **No**
Genetic conditions	□ **Yes**	□ **No**
Autism	□ **Yes**	□ **No**
Kidney or liver condition	□ **Yes**	□ **No**
Hearing impairment	□ **Yes**	□ **No**
ADD/ ADHD	□ **Yes**	□ **No**
Disabilities/ Special needs	□ **Yes**	□ **No**
Diabetes	□ **Yes**	□ **No**
Turberculosis	□ **Yes**	□ **No**
Cleft lip/ Palate	□ **Yes**	□ **No**
Birth defects	□ **Yes**	□ **No**
Heart murmur/ Defect	□ **Yes**	□ **No**
Congenital birth defects	□ **Yes**	□ **No**

If you marked yes to any of the above, please give details: _____

_____

_____

_____