

MINOR/CHILD REGISTRATION AND MEDICAL HISTORY
(PLEASE PRINT)

Date _____ Home Phone _____

Name of Minor/Child _____
Last Name First Name Initial Nickname

Street Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ Hobbies _____

INSURANCE

Father's/Guardian's Name _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Address (if different from patient's) _____

Home phone _____ Cell Phone _____

Home phone _____ Cell Phone _____

Soc. Sec.# _____ Birthdate _____

Soc. Sec.# _____ Birthdate _____

Email Address _____

Email Address _____

Employer _____

Employer _____

Employer Address _____

Employer Address _____

Work Phone _____

Work Phone _____

Do you have insurance coverage for minor/child? Yes No

Do you have insurance coverage for minor/child? Yes No

Plan Name _____

Plan Name _____

Group/Policy # _____

Group/Policy # _____

Phone No _____

Phone No _____

Address _____

Address _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service _____

Has the child complained about dental problems? Yes No Is fluoride taken in any form? Yes No

Does the child brush teeth daily? Yes No Any injuries to mouth, teeth, head? Yes No

Does the child use floss every day? Yes No Any unhappy dental experiences? Yes No

Any mouth habits – thumb-sucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc? Yes No

(OVER)

MEDICAL HISTORY

Minor/Child's Name _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor/Child under the care of a physician now? Yes No Medications _____

Receiving any medication or drugs? _____ Yes No _____

Ever been hospitalized? _____ Yes No Allergies _____

Ever had Surgery? _____ Yes No _____

Is there excessive bleeding when cut? _____ Yes No _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR IFFCULTY WITH ANY OF THE FOLLOWING? (Check all that apply):

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./HIV | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsion | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian _____ Date _____

RELEASE AND ASSIGNMENT

I certify that I am covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I am also responsible for any and all charges incurred for collection services.

Signature of Parent/Guardian _____ Date _____

In the event, I fail to pay my balance within 90 days from date of service I agree to pay all costs of collection, including attorney fees.

Signature of Parent/Guardian _____ Date _____

UPDATE (To be completed at a later visit)

Have there been any changes in the patient's health since last dental appointment? Yes No

If so, please describe _____

Is the patient taking any new medications? _____ if so, please list _____

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____