

# CHILDREN'S PATIENT REGISTRATION (under 18)

Date

Patient's Name \_\_\_\_\_ Sex  M  F Birthdate \_\_\_\_\_  
Last First Middle Initial

Patient's Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City Zip

Father/Guardian's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Last First Middle Initial

Father/Guardian's Address (if different than above) \_\_\_\_\_  
Street City Zip Phone

Father/Guardian's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_ Local No. \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Last First Middle Initial

Mother/Guardian's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_ Local No. \_\_\_\_\_

Referred to Office by \_\_\_\_\_

Nearest Neighbor or Relative \_\_\_\_\_  
Name Relationship Address Phone

Who is responsible for this account?  Father  Mother  Other If "other" please see receptionist

Father's  Mother's Driver's License # \_\_\_\_\_

## FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle Initial

Group No. \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Plan Code \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_  Insurance Co. \_\_\_\_\_

Patient's Relationship to Subscriber  Dependent  Other \_\_\_\_\_

Are you covered under more than one dental plan?  Yes  No If yes, please fill out next section.

## SECONDARY INSURANCE

Subscriber's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle Initial

Group No. \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Plan Code \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_  Insurance Co. \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

(Please Continue On Next Page)

## FOR OFFICE USE ONLY

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical Message:

1. No Message      2. See Medical      3. Premedicate      4. See Medical and Premedicate      5. Allergies

## CHILD'S MEDICAL HISTORY

Child's general health (please check):    Excellent    Good    Fair    Poor

Name and address of physician \_\_\_\_\_

Physician's Telephone # \_\_\_\_\_ Child's last complete physical \_\_\_\_\_

Is your child allergic to:    Penicillin    Codeine    Local injected Anesthetics

Child has no Allergies to Medications

Please list any other medications your child may be allergic to \_\_\_\_\_

Is your child receiving any medication now?    Yes    No   For What Purpose? \_\_\_\_\_

Does your child have any physical problems?    Yes    No   Does your child have any other allergies?    Yes    No

Does your child have any emotional problems?    Yes    No   Heart Murmur .....  Yes    No

**Has your child had or ever been treated for:**   Hepatitis .....  Yes    No

Asthma or Hay Fever .....  Yes    No   Kidney .....  Yes    No

Abnormal Blood Pressure .....  Yes    No   Blood transfusions.....  Yes    No

Bladder .....  Yes    No   AIDS .....  Yes    No

Cerebral Palsy.....  Yes    No   Malignancies/Cancer.....  Yes    No

Sinus Problems .....  Yes    No   Prolonged Bleeding.....  Yes    No

Congenital Heart Lesions.....  Yes    No   Radiation Treatment.....  Yes    No

Cough.....  Yes    No   Rheumatic Fever.....  Yes    No

Diabetes .....  Yes    No   Thyroid .....  Yes    No

Epilepsy.....  Yes    No   Tuberculosis.....  Yes    No

Cold Sores.....  Yes    No   Ulcers .....  Yes    No

Hearing Problems .....  Yes    No   Serious Accident .....  Yes    No

Heart Problems .....  Yes    No   Other \_\_\_\_\_

**Has a physician ever advised your child to take antibiotics prior to dental appointments?.....**  Yes    No

Please describe any current medical treatment including drugs, previous or pending surgery, recent injuries and illnesses, or any other information we should be aware of that has not been discussed.

\_\_\_\_\_  
\_\_\_\_\_

## CHILD'S DENTAL HISTORY

Has your child had any injuries to the mouth, teeth, or head?.....  Yes    No

Does your child have any mouth habits, ie. thumbsucking, nail biting, mouth breathing, etc. ....  Yes    No

Does your child clench or grind teeth during the day or night?.....  Yes    No

Date of Child's last dental visit? \_\_\_\_\_ Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

Reason for leaving child's last dentist? \_\_\_\_\_

Please add anything you feel is important for the doctor to know such as dental problems, attitude toward dentistry, unhappy dental experiences, etc. \_\_\_\_\_

\_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

## FOR OFFICE USE ONLY

Update Medical History \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_