PATIENT'S NAME _____

Last First Initial Date of Birth

PARENT'S NAME _____

Last First Initial

DENTAL HISTORY (circle appropriate answer)

1. Is this the child's first visit to a dentist? . . . . . YES NO
2. If not, how long since the last visit to the dentist? _____
3. When was the last time the teeth were cleaned? _____
4. Does child eat between meals? . . . . . YES NO
5. Does child eat sweets: candy, soda pop, chewing gum? . . . . . YES NO
6. Does child eat well balanced meals? . . . . . YES NO
7. Does child brush teeth upon arising? . . . . . YES NO
    a. When going to bed? . . . . . YES NO
    b. Right after eating meals? . . . . . YES NO
    c. After eating any food? . . . . . YES NO
8. Do you live in an area without fluoridated water? . . . . . YES NO
9. Have teeth been treated with fluorides?
10. Have any cavities been noted in the past
11. Where any teeth (baby or permanent removed by extraction?
    a. Was it suggested that the space be maintained?
    b. Was appliance placed?
12. Have there been any injuries to teeth, such as falls, blows, chips, etc?
    a. If so, described
13. Has child had any unfavorable dental experiences
14. How many children in your family
15. Has anyone in the family, including parents, had orthodontics?
16. Has child ever received a local anesthetic or any form of anesthetic?
17. Has child ever had occlusal sealants?

MEDICAL HISTORY

1. Is child in good health?
2. Is child under care of physician?
    a. If yes, since when
    b. Why
3. Name of physician
4. Is child receiving any medication?
    a. When
    b. Why
5. Has the child had any serious illness?
    a. When
    b. Why
6. Is the child allergic to penicillin, antibiotics or other drugs?
7. Does the child have any other allergies?
8. Has child had surgery?
9. Is surgery contemplated
10. Is child subject to profuse bleeding?
11. Is child subject to nervous disorders?
    a. Fainting?
    b. Dizziness?
12. Has child had history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

_____ _____

PARENT'S/GUARDIAN'S SIGNATURE **DATE**

COMMENTS:

CHILD DENTAL MEDICAL HISTORY

PATIENT'S NAME_____ Today's Date_____

DATE OF BIRTH_____

SOCIAL SECURITY NO_____

HOW DO YOU WISH TO BE ADDRESSED_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

TELEPHONE_____ CELL_____

PARENT'S NAME_____

PATIENT/PARENT EMPLOYED BY_____

PATIENT/PARENT SOCIAL SECURITY NO_____

SPOUSE/PARENT NAME_____

SPOUSE EMPLOYED BY_____

SPOUSE/PARENT SOCIAL SECURITY NO_____

WHO IS RESONSIBLE FOR THIS ACCOUNT

METHOD OF PAYMENT Insurance ☐ Credit Card ☐ Cash ☐

OTHER FAMILY MEMBERS IN THIS PRACTICE_____

_____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY, NOT LIVING WITH YOU_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____

NAME OF INSURANCE C0_____

ADDRESS_____

TELEPHONE_____

POLICY #_____

GROUP #_____

SOCIAL SECURITY #_____

DENTAL INSURANCE 2nd COVERAGE

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____

NAME OF INSURANCE C0_____

ADDRESS_____

TELEPHONE_____

POLICY #_____

GROUP #_____

SOCIAL SECURITY #_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE_____ DATE_____

CHILD REGISTRATION