CHILD REGISTRATION

Child's Name: ____Birthdate:___/___/____ Male/Female:_______

Address:_________________________________City:________________________State:____ Zip:_________

Phone:(____)________________ Nickname(if any):____________________

School Name:____________________ Current Age:____Current Grade:____ Last Dental Visit:___/___/____

Special Interests:____

Who may we thank for referring you to our office?:____

Father's Name:_________________________SSN:_____-____-_______ Birthdate:___/____/______

Address:_____________________________ City:_________________State:___Zip:________________

Home Phone:(____)_____________ Work Phone:(____)_________ Cell Phone: (____)______________

Employer:____Postition/Title:_____________________

Mother's Name: ________________________SSN:_____-____-______ Birth date:___/____/_____

Address:____________________________________City:__________________State:___Zip:______

Home Phone:(____)____________ Work Phone:(___)________ Cell Phone: (____)_______________

Employer:____Position/Title:_____________________

Child's Physician: _______________________________ Phone: _______________________

DENTAL INSURANCE 1ST COVERAGE

Employee Name___________________________________

Employee Date of Birth____________________________

Employer_______________________________________

Name of Insurance Co.____________________________

Policy #____

Social Security #___________________________________

DENTAL INSURANCE 2nd COVERAGE

Employee Name____________________________

Employee Date of Birth______________________

Employer___________________________________

Name of Insurance Co.______________________

Policy #_____________________________________

Social Security_______________________________

WE ARE IN-NETWORK PROVIDERS FOR WEA AND DELTA DENTAL *PREMIER* INSURANCE ONLY!
ALL OTHER INSURANCES WE ARE OUT-OF-NETWORK.
PATIENTS ARE RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE.
IF YOU DO NOT HAVE INSURANCE, WE DO ASK FOR PAYMENT IN FULL ON THE DAY OF SERVICE.

Dental History

Does your child brush teeth daily? YES NO

Do you assist child with tooth brushing? YES NO

Is dental floss used?How often?_______ YES NO

Are disclosing tablets used? YES NO

Is fluoride taken in any form? YES NO

Has child complained about dental problems? YES NO
If yes, explain_________________________________
____

Any unhappy dental experiences? YES NO

Any injuries to mouth-teeth-head? YES NO

Any mouth habits, thumbsucking, Nail biting, nursing bottle habits, pacifiers? YES NO

Orthodontic appliances worn now Or ever been? YES NO

Health History

Child's physician___________________________

Date of last physical exam? _________________

Is Child under care of physician now?YES NO

Is child receiving any medications? YES NO

Has child ever been hospitalized? YES NO

Has child ever had surgery? YES NO

Is there any allergy to penicillin or other drugs? YES NO

Has child any history of or difficulty with:
(circle all that apply)

Anemia Asthma Bladder Cerebral Palsy

Chicken Pox Chronic Sinus Convulsions

Diabetes Epilepsy Fainting Hearing Heart

Kidney Liver Malignancies Mastoid

Measles Mononucleosis Mumps Rheumatic Fever

Thyroid Tuberculosis Venereal Disease

Other:_____________________________________

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

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This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable on my child and will assume responsibility for fees associated with those procedures.

Name (Printed): _________________________________Signature: _____________________________________

Your Relationship to Child:__________________