PATIENT RECORD - CHILD'S REGISTRATION FORM

Date____________________

Name______________________________ Birthdate ____________ Age__________ Sex ______________
Home Address______________________________ City/Zip____________ Phone____________________
If P.O. box, please give physical address ______________________________ E-Mail Address ______________
Father's Name____________________ Where Employed ______________ Business Phone ____________
Business Address__________________ Soc. Sec. #________________ Birthdate ______________
Home Address____ Home Phone______________
Mother's Name____________________ Where Employed ______________ Business Phone____________
Business Address__________________ Soc. Sec. #________________ Birthdate______________
Home Address____ Home Phone______________
Your Bank ____ How Long______________
How did you find out about our office? (circle) Family Yellow Pages Newspaper Flyer Location
Friend__________ (name)______________________________
If you have no phone, please list a number you may be reached at to verify your appointments, etc.: ______________ Phone______________
Who can we contact in case of emergency______________________________ Phone______________
Name of nearest relative not living with you ______________________________ Phone______________
Have you or any member of your family been seen in this office?______List their names______________________
Method of Payment ______Cash__________Check__________Credit Card (Master Card, Visa, Discover Card) ______________

A REQUEST FOR PAYMENT AT THE TIME OF SERVICES RENDERED IS NO REFLECTION ON YOUR CREDIT. CASH ACCOUNTS ENABLE US TO OPERATE WITH MORE ECONOMY, THUS REDUCING YOUR COST OF TREATMENT.

DENTAL HISTORY

Last dental visit__________________ Purpose ________________ Purpose of today's visit ______________
Previous Dentist________________________ Address______________________________
Why are you changing dentists?____
Unfavorable experiences? If yes, please describe______________________________________
How many times a day does your child brush?______________________________________
How often does your child floss? (circle) never sometimes daily When? (circle) Morning Mid-day Evening
What type of toothbrush does your child use? (circle) Soft Medium Hard
Teeth sensitive to (circle) Heat Cold Sweets Biting
How would you describe your child's present dental health? (circle) Excellent Good Fair Poor
What is your main concern? (circle) Preventive maintenance cavities gums appearance bite toothache orthodontics
other - please describe
Do you like the appearance of your child's smile?__________ If not, what would you change?______________________
Is your household water supply from a well?______________________________________
Does your child receive a fluoride supplement at home or at school__________If yes describe ______________________

MEDICAL HISTORY

Child's Physician ____ Last Exam ______________
Is your child receiving medical treatment or has there been a change in health?______________________________
Please circle any word that applies to your child's health history:

Lupus	Chronic Fatigue	Abnormal Bleeding	Asthma
Rheumatic or Scarlet Fever	Radiation Therapy	Sinus Trouble	Tuberculosis
Heart Murmur	High Blood Pressure	Eye Problems	Chronic Stomach Problems
Pacemaker, Heart Valves	Heart Condition / Attack	Pregnant Now	Ulcers
Pins, Artificial Joints	Anemia	Arthritis	Kidney Trouble
Allergy to Penicillin	Hospitalized Recently	Hepatitis	Jaundice
Allergy to Codeine	Stroke	Diabetes	Skin Problems
Other Allergies	Taking Medication	HIV (AIDS virus)	Thyroid Problems
Epilepsy	Psychiatric Treatment	Chronic Headache	Cancer
			Other______________

List all medications currently being taken:____

____

I understand that I am responsible for an accurate medical history and fees for any dental service rendered including any necessary collection fees. The policy in our office is the parent who requests treatment for the child is responsible for all fees for service rendered.

____
Signature of parent / guardian requesting care Date