Patient Registration

Child

Name ______________________ Nickname ______________
(first) (last)

Age __________ Birthday ______________ Boy Girl (please circle)

Home address ______________________________

Home phone ______________________________

Do parents and child all live together? Yes | No

Separated parents: Whomever brings child to office will be person responsible for this account:

Parent ______________ Other ______________

To whom may we thank for your referral? ______________

Health History

Child's Physician ______________ Phone ______________

Is/Has Child:

	Yes	No	Notes
Any illness now?			
Type ______			
Receiving any medications or drugs?			
List ______			
Ever been hospitalized?			
Date ______			
Ever had surgery?			
Date ______			
Allergic to any medications / latex products? ______			
Are there any other allergies?			
List ______			

Has/Had any history of: circle Y for Yes or N for No

Anemia	Y	N	Hearing Problem	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Problem	Y	N	Seizure Disorder	Y	N
Bleeding Disorder	Y	N	Heart Murmur	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Hepatitis	Y	N	Tumors / Cancer	Y	N
Emotional Problem	Y	N	HIV / AIDS	Y	N	Special Needs / Other:		
Epilepsy	Y	N	Kidney Disease	Y	N	______		
Convulsions	Y	N	Liver Disease	Y	N	______		
Fainting / Passing out	Y	N	Mental Disorder	Y	N	______		

For office use only. Reviewed by DDS: ______________ Date ______________

Parent

Name ______________

D.O.B. / CDL# ______________

Occupation ______________

Employer ______________

Business Phone ______________

City ______________

Parent

Name ______________

D.O.B. / CDL# ______________

Occupation ______________

Employer ______________

Business Phone ______________

City ______________

Dental History

Reason for this appointment ______________

How do you feel about the condition of your child's mouth and teeth?

____

Child's personal interests ______________

____

Child's attitude toward dentistry ______________

Name of former dentist ______________

Are other family members patients here? Names ______________

Has Child:

	Yes	No	
Complained about dental problems?			If yes; ______
Had any injuries to mouth, teeth, or head?			If yes; ______
Had any mouth habits such as thumb sucking, nail-biting, mouth breathing, pacifier, etc?			If yes; ______
			If yes; ______
Had adverse reactions to anesthetics?			If yes; ______

____

Family Dental History

Extra / missing teeth?			If yes; ______
Gum disease?			If yes; ______
Orthodontic tx			If yes; ______
Large # of cavities			If yes; ______

I authorize routine dental procedures for my child. If I accept the proposed treatment plan, I also agree to the use of local anesthetics considered necessary by the dentist for the comfort and well being of the child.

Parent or Legal Guardian ______________ **Date** ______________

If you have Delta Dental insurance, Please complete insurance information on the reverse side.