Thank you for signing up with Dentistry for Children.

DENTISTRY FOR CHILDREN REGISTRATION

Child's Information

Date: ______________________________

Child's Full Name: ______________________________

Nickname: ______________________________ Age: ____________ Date of Birth: ____________________ M/F: ______

Other Siblings Coming to this Office: ______________________________

In Case of Emergency (Other than Parent):

1) ______________________________ Phone #: ____________________ Cell #: ____________________

2) ______________________________ Phone #: ____________________ Cell #: ____________________

Dental History

Date of last dental visit: ______________________________

Name of Previous Dentist: ______________________________

Address: ______________________________

City: __________________ State: ______ Zip: __________

Child's Physician: ______________________________

Date of last physical examination: ____________________

Is child under care of a physician now? y n

Has child complained about dental problems? y n

Any unhappy dental experiences? y n

Any injuries to mouth, teeth, or head? y n

Mouth habits: thumb sucking, nailbiting, mouth breathing, nursing, bottle or pacifier use, speech? y n

Any loss of teeth from trauma? y n

How many times a day does your child brush? y n

Do you assist child with tooth brushing? y n

Is dental floss used? y n

Is fluoride taken in any form? y n

Medical History

Is child receiving any medication or drugs?

1) ______________________ 2) ______________________

Is there any allergy to penicillin or other drugs?

1) ______________________ 2) ______________________

3) ______________________ 4) ______________________

Are there any other allergies: latex, red dye, flavorings, foot pollen, animals, dust, other? y n

Is there any excessive bleeding when cut? y n

Are there any emotional problems? y n

Has child had any history of or difficulty with any of the following? (please circle if yes)

anemia	ear infections	mastoid
asthma	epilepsy	mental disabilities
autism	fainting	mononucleosis
bladder	hearing	physical handicap
cerebral palsy	heart	rheumatic fever
chicken box	hepatitis	seizures
chronic sinus	H.I.V.	thyroid
chronic cough	kidney	tuberculosis
convulsions	liver	
diabetes	malignancies	

Other: ______________________________

____

Financial Information

Father's Full Name: ______________________ Date of Birth: ____________

Address: ______________________ City: ______________ State: ____ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Employer: ______________________ Social Security Number: ______________

Address: ______________________ City: ______________ State: ____ Zip: ______

Name of Insurance Co.: ______________________ Years Employed: ______

Address: ______________________ City: ______________ State: ____ Zip: ______

Group Number: ______________________ Subscriber Number: ______________

Mother's Full Name: ______________________ Date of Birth: ____________

Address: ______________________ City: ______________ State: ____ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Employer: ______________________ Social Security Number: ______________

Address: ______________________ City: ______________ State: ____ Zip: ______

Name of Insurance Co.: ______________________ Years Employed: ______

Address: ______________________ City: ______________ State: ____ Zip: ______

Group Number: ______________________ Subscriber Number: ______________

Step Father's/Mother's Full Name: ______________________ Date of Birth: ____________

Employer: ______________________ Social Security Number: ______________

Name of Insurance Co.: ______________________ Years Employed: ______

Address: ______________________ City: ______________ State: ____ Zip: ______

Group Number: ______________________ Subscriber Number: ______________

Person financially responsible (if other than parent): ______________________

Address: ______________________ City: ______________ State: ____ Zip: ______

Medical or DSHS coupons available for patient: Yes No

I hereby authorize payment directly to Dentistry for Children, LLC, of the group insurance benefits otherwise payable to me. To my best knowledge, information above is correct and complete. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Dentistry for Children, LLC to release information necessary to secure payment of benefits. I agree to be responsible for all charges for dental services paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim and consent to the use and disclosure of protected health information to carry out treatment, payment and healthcare operations.

Signature: ______________________________ Date: ____________