CHILD'S REGISTRATION & HISTORY

Date:_____

We would like to welcome you and your child to our office. Please tell us about your child.

Child's Full Name: _____ Nickname:_____

Age:_____ Date of Birth:_____ ☐ M ☐ F Weight (estimated): _____

Names of other siblings seen or coming to this office: _____

Is your child here for a specific reason or in pain? If so, what?_____

DENTAL HISTORY

Would you describe your child as: ☐ Shy ☐ Apprehensive ☐ Outgoing ☐ Other _____

Has your child been to another dental office? ☐ Yes ☐ No If yes, name of previous dentist: _____

Date of last visit: _____

Has your child ever been sedated for dental treatment? ☐ Yes ☐ No If yes, please describe:_____

Has your child had any injuries to mouth, teeth, or head? ☐ Yes ☐ No _____

Has your child had any unhappy dental experiences? ☐ Yes ☐ No _____

Does your child have any of the following oral habits: ☐ Thumb / Finger Sucking ☐ Nail Biting ☐ Mouth Breating
☐ Nursing / Bottle ☐ Pacifier Use

Is fluoride taken in any form? ☐ Tablet ☐ Liquid ☐ Fluoride Mouth Rinse

Has your child complained about dental problems? ☐ Yes ☐ No _____

MEDICAL HISTORY

Child's Physician: _____ Phone #:_____

Has your child been to the hospital or had a serious injury in the last six months? ☐ Yes ☐ No

Is your child presently under the care of a physician for any medical problem? ☐ Yes ☐ No

Is your child currently taking any medicines or herbal supplements? ☐ Yes ☐ No

1)_____ 2)_____ 3)_____ 4)_____

Does your child now have, or ever had, a history of the following?

☐ ADD / ADHD
☐ Allergies to Food/Medications/Other (for example, penicillin, peanuts, latex, red dye). Please list_____
☐ Anemia
☐ Asthma / Other Lung Disease
☐ Autism
☐ Autoimmune Disease
☐ Behavior Problems
☐ Birth Defects / Congential Disease
☐ Bone or Joint Problems or Surgery
☐ Cancer / Malignancies / Leukemia
☐ Cerebral Palsy
☐ Chronic Tonsil / Adenoid / Ear Infections
☐ Cleft Lip / Palate
☐ Cold Sores
☐ Convulsions / Seizures / Epilepsy / Fainting
☐ Congenital Birth Defect
☐ Developmental Delay
☐ Diabetes
☐ Eating Disorder
☐ Emotional Problems
☐ Eye Problems / Glaucoma / Vision Impairment
☐ Genetic Syndrome
☐ Hearing / Speech Problems
☐ Heart / Murmur / Defect / Surgery / Antibiotic Required
☐ Hemophilia or Bleeding Problems
☐ Hepatitis or Liver Disease
☐ Kidney Disease or Bladder Condition
☐ Learning Disability
☐ Nutritional Deficiency
☐ Orthopedic Problems
☐ Premature Birth (Weight _____)
☐ Psychiatric Disorder
☐ Rheumatic Fever
☐ Snoring at Night
☐ Spina Bifida
☐ Sickle Cell Anemia
☐ Thyroid
☐ Tuberculosis (TB)
☐ Other _____

Has your child experienced an immuno-compromised condition, organ transplant or HIV? ☐ Yes ☐ No

If yes, please explain specific conditons:_____

_____

(Office Use) _____

_____

_____

_____

Doctor's Initials: _____ Date _____

FAMILY INFORMATION AND FINANCIAL RESPONSIBILITY

Father / Stepfather / Partner / Legal Guardian / Foster Parent Information (please circle):

_____ Date of Birth:_____
(FIRST) (MIDDLE INITIAL) (LAST)

Mailing Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Email _____ May we contact you on cell and/or email y n

Employer: _____ Social Security Number:_____

Name of Insurance Co.:_____ | Name of 2nd Insurance Co.: _____

Group Number: _____ | Group Number: _____

Subscriber Number:_____ | Subscriber Number:_____

Mother / Stepmother / Partner / Legal Guardian / Foster Parent Information (please circle):

_____ Date of Birth:_____
(FIRST) (MIDDLE INITIAL) (LAST)

Mailing Address: _____ City:_____ State:_____ Zip:_____
(IF NOT THE SAME AS ABOVE)

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Email _____ May we contact you on cell and/or email y n

Employer: _____ Social Security Number:_____

Name of Insurance Co.:_____ | Name of 2nd Insurance Co.: _____

Group Number: _____ | Group Number: _____

Subscriber Number:_____ | Subscriber Number:_____

Step Parent / Partner / Legal Guardian / Foster Parent (please circle):

_____ Date of Birth:_____
(FIRST) (MIDDLE INITIAL) (LAST)

Mailing Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Employer: _____ Social Security Number:_____

Name of Insurance Co.:_____ | Name of 2nd Insurance Co.: _____

Group Number: _____ | Group Number: _____

Subscriber Number:_____ | Subscriber Number:_____

Where does patient(s) reside? ☐ Father ☐ Mother ☐ Other _____

Emergency Contact Person (friend or relative WITH DIFFERENT PHONE NUMBERS THAN ABOVE)

Name:_____ Relationship:_____ Home#:_____ Cell#:_____

Does your child have coverage through the state of WA: ☐ Yes ☐ No Child's ID #_____

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 not 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.

Print Name_____ Relationship to Patient_____

Signature: _____ Date:_____