Welcome

kids&teens dental place

Patient Registration Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. TELLS US ABOUT YOUR CHILD

Child's Name: First_____ Last_____ Mi._____
Nickname: _____ ☐ Male ☐ Female
Child's Birthdate ____/____/____ Child's Age _____ SSN:_____
Child's Home Address: _____
City_____ State_____ Zip_____
Child's Home # (____)_____
School_____ Grade_____
Siblings that we treat_____

2. MOTHER'S INFORMATION

Name: First_____ Last_____ Mi._____
Mother Stepmother Guardian Birthdate ____/ ____/ ____
Employer_____ Work # (_____)_____ Ext. _____
Home # (_____)_____ Cellular # (_____)_____
SS # _____ DL # _____
Email Address_____

3. FATHER'S INFORMATION

Name: First_____ Last_____ Mi._____
Father Stepfather Guardian Birthdate ____/ ____/ ____
Employer_____ Work # (_____)_____ Ext. _____
Home # (_____)_____ Cellular # (_____)_____
SS # _____ DL # _____
Email Address_____

4. WHO IS ACCOMPANYING THE CHILD TODAY?

Name: First_____ Last_____ Mi._____
Relationship_____
Do you have legal custody of the child? ☐ Yes ☐ No

5. PERSON RESPONSIBLE FOR ACCOUNT

Name: First_____ Last_____ Mi._____
Relationship_____
Work # (_____)_____ Ext. _____ Home # (_____)_____
Cellular # (_____)_____ Email Address_____
Billing Address: _____
City_____ State_____ Zip_____

6. PRIMARY DENTAL INSURANCE

Insurance Co. Name_____ Insurance Co. Phone # _____
Insurance Co. Address_____ City_____ State_____ Zip_____
Policy Holder's Name: First_____ Last_____ Mi._____
Policy Holder's Birthdate ____/ ____/ ____ SS # _____
Policy Holder's Employer_____
Relationship to Patient_____

7. WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

Medical History

Child's Name_____ **Nickname**_____

Date of Birth_____ **Weight**_____ **Last physical exam**_____ **Last immunizations**_____ **Pregnant Y/ N**

Primary Care Provider_____ **Phone**_____

Specialist_____ **Phone**_____

1. Does your child have any major health problems? Y/ N If yes, explain_____

2. What medications is your child currently taking? What For? _____

3. Was your child born premature? Y/ N If yes, explain_____

Weeks of gestation? _____ Birth Weight? _____

Was a feeding tube used? Y/ N How long? _____

Was a breathing tube used? Y/ N How long? _____

4. Has your child been hospitalized? Y/ N If yes, explain_____

5. Has your child ever had surgery? Y/ N If yes, explain_____

6. Does your child have a heart murmur or heart defect? Y/ N If yes, explain_____

Was the murmur present at birth? Y/ N

Type of murmur? _____

Does your child have a heart card? Y/ N

Has your child been seen by a cardiologist? Y/ N When? _____

When is the next cardiology appointment? _____

Does the child require antibiotics for heart? Y/ N

Has your child had heart surgery or need heart surgery? Y/ N

7. Is your child currently being treated by a physician? Y/ N If yes, explain_____

8. Does your child suffer from allergies? Y/ N If yes, explain _____

9. Has your child ever experienced an unfavorable reaction? Y/ N If yes, please explain below

Please circle:

Drugs Antibiotics Foods Lactose intolerant

Metals Local Anesthetics Dyes Acrylic Latex

Other _____

Rash? Y/ N Treatment? Y/ N Hives? Y/ N Treatment? Y/ N

Anaphylaxis? Y/ N Treatment? Y/ N

10. Does your child have Asthma? Y/ N

Last Asthma attack?_____

What causes an attack?_____

Has your child ever been hospitalized for Asthma? Y/ N

Medications for Asthma?_____

11. Does your child have diabetes? Y/ N

How long have they been a diabetic? _____

Type I or II Medication_____

Frequency? _____

12. Has your child ever undergone general anesthesia? Y/ N If yes, explain _____

13. Does your child have a history of developmental or behavior problems? Y/ N If yes explain below

Please circle:

ADD ADHD OCD ODD Depression Autism Other_____

14. Has or does your child have a history or difficulty with any of the following?

Please circle:

AIDS	**High Blood Pressure**	**Cancer**	**Tuberculosis**	**Ulcers**	**Heart**
Liver	**Hepatitis**	**Anemia**	**Seizures/ Epilepsy**	**RSV**	**Bleeding Disorders**
Arthritis	**Rheumatic Fever**	**Autism**	**Speech Impairment**	**Chronic Sinus**	**Down Syndrome**
Visual Impairment	**Head Ache**	**Cerebral Palsy**	**Ears/ Hearing**	**Snoring or Sleep Apnea**	**Bladder Infections**
Smoking	**Tonsils/ Adenoids**	**Cystic Fibrosis**	**Obesity**	**Eczema**	**Under Weight**
Thyroid	**Kidneys**	**Eating Disorders**	**Cleft lip/ Cleft Palate**		

Dental History

Date of Last Dental Visit: _____ Dentist Name: _____
Services Rendered: _____ Were x-rays taken? Y/ N

15. Does your child have any dental complaints? Y/ N If yes, explain _____
16. Does your child have any swelling or infection in the mouth? Y/ N If yes, explain _____
17. What was your child's behavioral response to past dental care? _____
18. What is your child's attitude towards dentistry? _____
19. Are YOU anxious about the Dentist? Y/ N When was YOUR last check-up? _____ Do YOU have cavities? Y/ N
20. Does your child play sports? Please list:_____ Does your child wear a mouth guard? Y/ N
21. Does your child play a musical instrument? If yes, please list? _____
22. Any injuries to the teeth, mouth, TMJ, or head? Y/ N If yes, explain _____
When did the injury happen? _____ Did you receive emergency dental care? Y/ N

24. Has your child had any of the following?

Bruxism (Grinding)	TMJ/Joint Problems	Snoring	Thumbsucking
Lip Biting	Pacifier	Nail biting	Fingersucking
Nursing	Bottle		

25. Does your child brush daily? Y/ N How often? _____ Do you assist? Y/ N
26. Does your child floss? Y/ N How often? _____ Do you assist? Y/ N
27. Is fluoride taken? ____Water ____Toothpaste ____Chewable tablets ____ Rinse ____ Fluoride drops (strength) _____
28. Is your city on _____city or _____well water? If well water, what is the fluoride content? _____
29. Does your child use any of the following?
Please circle:
Sippy cup Bottle Nursing
If so, how often? _____ What is in the bottle or sippy cup? _____

30. Does your child drink any of the following?
Please circle:
Soda Kool Aid Juice Sports drinks Milk Water
If so, how often? _____

31. Does your child snack between meals? Y/ N If yes, what types of snacks? _____ Candy_____
32. Do you desire complete dental services for your child? Y/ N If no, explain _____

ACKNOWLEDGMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I certify that I am legally qualified to provide the above information. I am the child's (please circle) mother, father, grandfather, grandmother, foster parent, or other. You must provide documentation that you are legally able to sign this form.

Parent's Name:_____ Date: _____

Child's Name: _____ D.O.B: _____

STAFF REVIEW: