

Registration

Date: _____

Child #1 Name: _____ DOB: __/__/__

Child #2 Name: _____ DOB: __/__/__

Child #3 Name: _____ DOB: __/__/__

Child #4 Name: _____ DOB: __/__/__

Child #5 Name: _____ DOB: __/__/__

Home address: _____

City _____ State ____ Zip _____

Home phone: (____) _____

<input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Father <input type="checkbox"/> Mother
Name: _____	Name: _____
Address: <input type="checkbox"/> same _____	Address: <input type="checkbox"/> same _____
City _____ State ____ Zip _____	City _____ State ____ Zip _____
Cell Phone: (____) _____	Cell Phone: (____) _____
SSN: _____ DOB: __/__/__	SSN: _____ DOB: __/__/__
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____
Business Phone: _____	Business Phone: _____
Dental Insurance: _____	Dental Insurance _____

How did you find out about our office: _____

Consent for treatment: I authorize the performance of any necessary dental treatment recommended by this office for the above named patient(s) and will be responsible for payment of this account.

Sign: _____ Date: _____ Relationship to Child(ren) _____

Medical and Dental History

Date: _____

Child's Name _____ Name child goes by: _____

Child's Birthdate: _____ Age: _____ Gender: ____ Male ____ Female

Dental Insurance: ☐ Father's Insurance ☐ Mother's Insurance ☐ Other: _____

Child's Interest Or Hobbies _____

School _____ Grade _____

Purpose of this Appointment: ☐ Checkup ☐ Trauma ☐ Cavities ☐ Pain ☐ 2nd Opinion

Other: _____

Comments regarding today's appointment: _____

Has Your Child Had any Unhappy Dental Visits? ☐ Yes ☐ No Explain: _____

How Often are Child's Teeth Brushed? ☐ Morning ☐ Bedtime ☐ Other _____ By Whom: _____

Does Child Use Dental Floss? ☐ Yes ☐ No How often: _____

Any Previous Injuries to: ☐ Teeth ☐ Mouth ☐ Jaws ☐ Head Describe _____

Any Mouth Habits: ☐ Thumb or Finger Sucking ☐ Pacifier ☐ Nail Biting ☐ Other _____

Name of Child's Physician: _____

Has Your Child Ever Had Any of the Following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Kidney Conditions | <input type="checkbox"/> Sensory Processing Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Liver Conditions | <input type="checkbox"/> Handicap Conditions |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Disease/Murmur | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Autism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Cleft Lip/ Cleft Palate | <input type="checkbox"/> Asperger's | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Reflux/ GI problems | <input type="checkbox"/> Speech Delay | <input type="checkbox"/> Other |
| <input type="checkbox"/> Tongue Tie/Lip Tie | <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> MTHFR mutation | |

If Any of the Above are Checked, Please Explain:

List any medications your child is taking: _____

Does Your Child Have Any Special Problems Not Listed:

Signature of Parent/Guardian: _____

Relationship to patient: _____
