MINOR/CHILD REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date______________________________ Home Phone_____________________________

Name of Minor/Child ____
Last Name First Name Initial Nickname

Street Address____ City________________________ State___________ Zip_____________________

Sex: ☐ M ☐ F Age_____________ Birthdate__________________________ Hobbies____

INSURANCE

Father's/Guardian's Name___________________________________

Address (if different from patient's) ____________________________

____

Home phone _________________ Cell Phone___________________

Soc. Sec.#____________________ Birthdate____________________

Email Address____

Employer____

Employer Address____

Work Phone____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name____

Group/Policy #____

Phone No____

Address____

____

Mother's/Guardian's Name___________________________________

Address (if different from patient's) ____________________________

____

Home phone ________________ Cell Phone____________________

Soc. Sec.#____________________ Birthdate____________________

Email Address____

Employer____

Employer Address____

Work Phone____

Do you have insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name____

Group/Policy #____

Phone No____

Address____

____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name____ Relationship_________________________ Phone__________________________

Name____ Relationship_________________________ Phone__________________________

DENTAL HISTORY

Date of last visit to a dentist ________________________________ For what service ____

Has the child complained about dental problems? ________☐ Yes ☐ No

Does the child brush teeth daily?_____________________ ☐ Yes ☐ No

Does the child use floss every day?___________________ ☐ Yes ☐ No

Is fluoride taken in any form? ________________________☐ Yes ☐ No

Any injuries to mouth, teeth, head?___________________ ☐ Yes ☐ No

Any unhappy dental experiences? ___________________ ☐ Yes ☐ No

Any mouth habits – thumb-sucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc? ________________________________☐ Yes ☐ No

(OVER)

MEDICAL HISTORY

Minor/Child's Name____ City/State ___________________________ Phone ____________________

Date of last physical examination ______________________________ Results____

Is Minor/Child under the care of a physician now?______ ☐ Yes ☐ No

Receiving any medication or drugs? ________________ ☐ Yes ☐ No

Ever been hospitalized?__________________________ ☐ Yes ☐ No

Ever had Surgery? ______________________________ ☐ Yes ☐ No

Is there excessive bleeding when cut? _______________ ☐ Yes ☐ No

Medications____

____

____

Allergies____

____

____

HAS MINOR/CHILD HAD ANY HISTORY OF OR IFFICULTY WITH ANY OF THE FOLLOWING? (Check all that apply):

☐ A.I.D.S./HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsion	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian ____ Date________________________________

RELEASE AND ASSIGNMENT

I certify that I am covered by insurance with ____
Name of Insurance Company(ies)

and assign directly to Dr. ____________________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I am also responsible for any and all charges incurred for collection services.

Signature of Parent/Guardian ____ Date________________________________

In the event, I fail to pay my balance within 90 days from date of service I agree to pay all costs of collection, including attorney fees.

Signature of Parent/Guardian____ Date______________________________

UPDATE (To be completed at a later visit)

Have there been any changes in the patient's health since last dental appointment? ☐ Yes ☐ No

If so, please describe____

Is the patient taking any new medications? __________________________ if so, please list____

Patient/Guardian Signature____ Date________________________________

Dentist Signature____ Date________________________________