



## CHILD REGISTRATION FORM

### PATIENT INFORMATION

Name: \_\_\_\_\_  
First Middle Last What name do you prefer to be called?  
Address: \_\_\_\_\_  
Street Apt. # City State Zip Code  
Home phone: ( ) \_\_\_\_\_ Birthday: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_  
In case of emergency, Who should be notified? \_\_\_\_\_ Telephone# ( ) \_\_\_\_\_

### INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Sec.# \_\_\_\_\_  
Name of employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Business # ( ) \_\_\_\_\_ Are calls allowed? \_\_\_\_\_  
Name of Dental Ins. Company: \_\_\_\_\_ Group # \_\_\_\_\_  
Who is responsible for any balance not paid by the ins. company? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### DENTAL HISTORY

When was your child's last dental check up? \_\_\_\_\_  
How many times a day does yur child brush his/her teeth? \_\_\_\_\_ Do you brush your child's teeth? \_\_\_\_\_  
Are your child's teeth sensitive to hot or cold? YES NO  
Does your child snore? YES NO  
Does your child grind or clench his/her teeth? YES NO  
Have dental procedures ever been recommended to you that you did not have done? \_\_\_\_\_  
If yes, what procedure? \_\_\_\_\_  
Are you having any pain or discomfort at this time? YES NO Where? \_\_\_\_\_  
What is your main dental concern today? \_\_\_\_\_

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MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Is your child under the care of a physician? YES NO If yes, what is the condition being treated? \_\_\_\_\_

Does your child have any drug allergies or reacted adversely to any medications? \_\_\_\_\_

Does your child have any history of:

Asthma? YES NO

Blood Disease? YES NO

Cancer? YES NO

Diabetes? YES NO

Epilepsy? YES NO

Heart Murmur? YES NO

Hepatitis A, B or C? YES NO

Mitral Valve Prolapse? YES NO

Rheumatic Fever? YES NO

Does your child have any disease/condition not listed? \_\_\_\_\_

FINANCIAL AGREEMENT

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the total balance on my account for any professional services rendered. Should my account become delinquent, I agree to pay interest at the rate of 1 1/2% per month (18% annual percentage rate). I also agree to pay all collection costs including attorney fees incurred. 33 1/3% will be added to accounts transferred out to collection.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

A CHARGE WILL BE MADE FOR APPOINTMENTS BROKEN  
OR CANCELLED WITHOUT 48 HOURS ADVANCE NOTICE