

PLEASE PRINT

PATIENT INFORMATION – MINOR/CHILD REGISTRATION

Phone Number _____

Date _____

Name of Minor/Child _____
Last Name First Name Middle Initial

Sex: Male _____ Female _____ Age _____ Birthdate _____ Nickname _____

Hobbies: _____

Home Address: _____
Street City State Zip

Whom may we thank for referring you? _____

PARENT / GUARDIAN INFORMATION

Father's/Guardian's Name _____
Address (if different from patient's) _____

Mother's/Guardian's Name _____
Address (if different from patient's) _____

Home Phone # _____

Work Phone # _____

Cell # _____

Cell # _____

Email _____

Email _____

Employer _____

Employer _____

Address _____

Address _____

City _____ State _____

City _____ State _____

Soc Sec # _____ Birthdate _____

Soc Sec # _____ Birthdate _____

Driver License # _____

Driver License # _____

Do you have dental insurance for minor/child
Yes _____ No _____

Do you have dental insurance for minor/child
Yes _____ No _____

EMERGENCY CONTACT

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

Name _____ Relationship _____ Phone _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what Service _____

Has child complained about dental problems (YES / NO) Is fluoride taken in any form (YES / NO)

Does child brush teeth daily (YES / NO) Any injuries to mouth, teeth, head? (YES / NO)

Does child use floss everyday (YES / NO) Any unhappy dental experiences (YES / NO)

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	_____	_____
Receiving any medication or drugs?	_____	_____
Ever been hospitalized?	_____	_____
Ever had surgery?	_____	_____
Is there excessive bleeding when cut?	_____	_____

Medications: _____

Allergies: _____

HAS MINOR/CHILD HAD ANY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING (PLEASE CHECK 'YES' OR 'NO')

YES	NO		YES	NO		YES	NO	
_____	_____	A.I.D.S./H.I.V.	_____	_____	Drug/Alcohol Abuse	_____	_____	Mononucleosis
_____	_____	Anemia	_____	_____	Epilepsy	_____	_____	Rheumatic
_____	_____	Asthma	_____	_____	Fainting	_____	_____	Fever
_____	_____	Heart	_____	_____	Heart Problems	_____	_____	Thyroid Disease
_____	_____	Murmur	_____	_____	Hepatitis	_____	_____	Tuberculosis
_____	_____	Cerebral Palsy	_____	_____	Kidney Disease	_____	_____	Other
_____	_____	Convulsions	_____	_____	Liver Disease			
_____	_____	Diabetes						

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 my minor/child is covered by insurance with _____

Name of Insurance Company

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

Signature of Parent/Guardian

Date

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date

Signature

FOR OFFICE USE ONLY – UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? (YES / NO)

If yes, please describe _____

Is patient taking any new medications? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? (YES / NO)

If yes, please describe _____

Is patient taking any new medications? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____