

CHILD REGISTRATION FORM

Child's Name _____ Birthday _____ Age _____
Telephone Home: _____ Emergency: _____
Address _____ City _____ ZIP _____
Father's Name _____ Father's Employer _____
Mother's Name _____ Mother's Employer _____
Father's Social Security # _____ Mother's Social Security # _____
Former Dentist _____ Date of last visit _____

Do you have dental insurance? YES _____ NO _____ If yes, Company or Local
Primary _____ Secondary _____

Whom may we thank for referring you to our office? _____

Please check one:

- I am establishing child as a new patient and wish him/her to receive an initial examination.
 I wish my child to receive emergency treatment only.

List child's current dental problems, if any. _____
Does dental treatment make child nervous? _____

MEDICAL HISTORY

Physician's name and location _____

Is child undergoing treatment now? _____ If yes, please explain _____

Please list any medications child is taking at this time. _____

Please list any allergies to drugs/medications _____

Does child have any of the following? If yes, please circle.

Heart problems:	Cancer	Lung problems	Diabetes
Heart Murmur	Epilepsy	Hepatitis A, B, or C	TB
Mitral Valve Prolapse	Lung Problems	Joint Replacement	Mouth Sores
Pacemaker	Asthma	Bleeding problems	Dizziness
Bypass Surgery	HIV/Aids	Back/Spine Problems	Fainting
Heart Attack	Kidney/Liver	Psychiatric Problems	Metal Allergy
Rheumatic Fever	Infections	Pregnancy	Latex allergy
High Blood Pressure	Other _____		

Please list any physical problems child may have that may affect our ability to treat him/her. _____

Have child ever been hospitalized? _____ If so, explain _____

Date _____ Signature of Parent _____