WELCOME

Child Dental Registration and History

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's date:________________________________

Child's name:________________________________

First Middle Last

Preferred name:_______________ ☐Male ☐Female

Child's birthday:______________ Child's age:_______

School: ___________________________ Grade: _____

Child's home #: ______________ SS#:_____________

Child's home address:

____

APT/ CONDO #

____

City State Zip

Email Address: ______________________________

Whom we may thank for referring you? _____________

2 Who Is Accompanying Your Child Today?

Name: ______________ Relation: _________________

Do you have legal custody of this child? ☐ Yes ☐ No

Other Family members seen by us:_________________

____

Previous/ Present Dentist: _______________________

(Please circle)

Last visit date: _______________________________

Parent's marital status: ☐ Single ☐ Widowed ☐ Partnered ☐ Married ☐ Divorced ☐ Separated

3 Mother's Information: ☐ Step Mother ☐ Guardian

Name: _________________Birthday: ____/ ____/ _____

Email Address: ______________________________

Cell phone: ____________Home phone: ____________

Employer: _____________Work phone: ____________

SSN: _________________ Driver Lic:_____________

Father's Information: ☐ Step Father ☐ Guardian

Name: _________________Birthday: ____/ ____/ _____

Email Address:_______________________________

Cell phone: ____________ Home phone:____________

Employer: _____________Work phone:_____________

SSN: _________________Driver Lic: ______________

4 Person Responsible For Account

Name: ____________________ Relation: __________

Address:_____________________________________

____

City State Zip

Cell phone: ____________ Home phone:___________

Employer:____________________________________

Occupation: __________________________________

Work phone: ______________________ Ext:_______

SS #: _______________ Driver Lic:_______________

Who Is Responsible For Making Appointments?

Name:_______________________________________

5 Primary Dental Insurance

Insurance Co. Name: ____________________________

Insurance Co. Address: __________________________

Insurance Co. Phone: ___________________________

Group number:_________________________________

Policy Owner's Name: ___________________________

Relationship to Patient: _________________________

Policy Owner's Birthday: ________________________

Insurance ID #/ SSN #: __________________________

Policy Owner's Employer: ________________________

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: ____________________________

Insurance Co. Address: __________________________

Insurance Co. Phone: ___________________________

Group number:_________________________________

Policy Owner's Name: ___________________________

Relationship to Patient: _________________________

Policy Owner's Birthday: ________________________

Insurance ID #/ SSN #: __________________________

Policy Owner's Employer: ________________________

Orthodontic Coverage? ☐ Yes ☐ No

Please continue on the next page!

6 What would you like for us to do for your child today? ________________

____

Has your child ever had a serious/ difficult problem associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No

Is your child taking fluoridated supplements? Yes No

Has your child ever had any pain/ tenderness in his/ her jaw joint (TMJ/ TMD)? Yes No

Does your child brush his/ her teeth daily? Yes No

Does your child floss his/ her teeth daily? Yes No

Child's Physician: ________________________

Phone #: ______________ Date of last visit: _________

Is your child currently under care of a physician? Yes No

Please describe your child's current physical health:

Good Fair Poor

Has your child ever taken Phen-Fen? Yes No

(Also known as Redux or Pondimin)

If so, when? ________________________

Please list all prescription/ over the counter or herbal supplement drugs that your child is currently taking:

____

____

Aside from items below, list all drugs/ materials that your child is allergic to: ____________________

____

Latex? Yes No **Metals/ Nickel?** Yes No

Plastic? Yes No

7 Has your child ever had any of the following medical problems?

ADD/ ADHD	Y N	Hearing Impairment	Y N
Any Hospital Stays	Y N	Heart Murmur	Y N
Any Operations	Y N	Hemophilia	Y N
Artificial Bones/ Joints	Y N	Hepatitis (Type ______)	Y N
Asthma	Y N	HIV +/ AIDS	Y N
Bleeding Problems	Y N	Kidney Problems	Y N
Cancer	Y N	Liver Problems	Y N
Congenital Heart Defect	Y N	Rheumatic/ Scarlet Fever	Y N
Convulsions/ Epilepsy	Y N	Sickle Cell Disease/ Traits	Y N
Diabetes	Y N	Tuberculosis (TB)	Y N

Please list any serious medical problems that your child has had: ________________________

____

____

8 Does/ did your child experience any of the following?

Lip Sucking/ Biting	Y N	Mouth Breather	Y N
Speech Problems	Y N	Tongue Thrust	Y N
Nail Biting	Y N	Nursing Bottle Habits	Y N
Thumb/ Finger Sucking	Y N	Clenching/ Grinding Teeth	Y N

9

I understand that the information that I have given is correct to the best of my knowledge, 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 Dr. Izadi and her staff to perform the appropriate X-rays and necessary dental services my child may need. I understand that I am financially 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 insurance submissions. The Parent or Guardian who accompanies the child is responsible for payment at time of service.

____

Signature of parent or guardian Date

THANK YOU!

OFFICE USE ONLY

Doctor's Comments: ________________________

____

Signature: ________________________ Date: ______________