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)
____
____

Home Phone # __________________________________

Cell #____

Email ____

Employer _____________________________________

Address ______________________________________

City ______________________State _________

Soc Sec # __________________ Birthdate ___________

Driver License # _______________________________

Do you have dental insurance for minor/child
Yes __________ No ________

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

Work Phone # __________________________________

Cell # ____

Email ____

Employer _____________________________________

Address ______________________________________

City _____________________________ State _______

Soc Sec # __________________ Birthdate ___________

Driver License # _______________________________

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 Fever
______	______	Asthma	______	______	Fainting	______	______	Thyroid Disease
______	______	Heart Murmur	______	______	Heart Problems	______	______	Tuberculosis
______	______	Cerebral Palsy	______	______	Hepatitis	______	______	Other
______	______	Convulsions	______	______	Kidney Disease			
______	______	Diabetes	______	______	Liver Disease			

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 ____