PATIENT REGISTRATION

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be happy to assist you. Thank you for trusting our team with your child's dental health.

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

Birthdate ________________ Age__________ Gender ☐ Male ☐ Female Preferred Name __________________________

Home Address ____
Street City State Zip

Confirm Appts with: Name ________________________________ Relationship to child ______________________

Cell Phone________________________ Email Address ____

Does your Minor/Child have insurance coverage? ☐ Y ☐ N Dental Insurance ☐ Medicaid ☐ ID # ____________________

How were you referred to us? ☐ Internet Search ☐ Doctor/Dentist ☐ Website ☐ Facebook ☐ Friend/Family ☐ Sibling

DENTAL HISTORY

Date of last visit to a dentist ____________________ Reason for visit? ______________________________________

Does child brush teeth daily? ☐ Y ☐ N Does child use floss every day? ☐ Y ☐ N Is fluoride taken in any form? ☐ Y ☐ N

Any injuries to mouth, teeth, head? ☐ Y ☐ N Please explain ______________________________________

Has child complained about dental problems? ☐ Y ☐ N Please explain______________________________________

Any unhappy dental experiences? ☐ Y ☐ N Please explain______________________________________

MEDICAL HISTORY

	YES	NO	
Is minor/child under care of a physician now?	☐	☐	Physician______________________ Phone______________
Current medications or drugs?	☐	☐	Medications______________________________________
Hospitalized in the last 2 years?.	☐	☐	______________________________________
Surgery in the last 2 years?.	☐	☐	______________________________________
Is there excessive bleeding when cut?	☐	☐	______________________________________

Is minor/child allergic to any of the following? If yes, please check (√) below. ☐ No known allergies

☐ Acrylic ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Azithromycin ☐ Other Allergy__________________________

Has minor/child had a history of or difficulty with any of the following? If yes, please check (√) below ☐ No to all

☐ ADD/ADHD	☐ AIDS/HIV	☐ Anemia	☐ Asthma	☐ Autism
☐ Bladder Problems	☐ Cancer	☐ Cerebral Palsy	☐ Chicken Pox	☐ Convulsions
☐ Diabetes	☐ Drug/Alcohol Abuse	☐ Epilepsy/Seizures	☐ Hearing Problems	☐ Heart Murmur
☐ Heart Problems	☐ Hemophilia	☐ Hepatitis	☐ Kidney Problems	☐ Liver Disease
☐ Measles	☐ Mononucleosis	☐ Mumps	☐ Rheumatic Fever	☐ Sinus Problems
☐ Thyroid Disease	☐ Tuberculosis	☐ Other ______________________		