DENTISTRY FOR CHILDREN

CYNDA HILL, D.D.S.

PATIENT'S REGISTRATION AND HISTORY

Patient's Name _____ Nickname _____

FIRST MIDDLE LAST

Sex ☐ Male ☐ Female Birthdate _____ Age _____ School _____ Grade _____

Is this an emergency visit? ☐ Yes ☐ No

Is this your child's first dental visit? ☐ Yes ☐ No

If no, name of former dentist? _____ Date of last visit _____ Purpose of today's visit _____

Have any other children in your family been a patient in this office before? ☐ Yes ☐ No Name _____

Present dental problem as you see it (if any) _____ Date last dental x-rays: _____

Has your child had any bad past dental experiences? ☐ Yes ☐ No Explain _____

Name(s) and ages of any brothers/sisters _____

Favorite interest _____ Favorite sport _____

Name of family dentist _____

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

MEDICAL INFORMATION

Patient's Pediatrician _____ Address _____ Phone _____

Date of last physical _____

Is your child in good health? ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

Is your child being treated for any condition presently? ☐ Yes ☐ No

If so, explain: _____

Is your child taking any medications or drugs? ☐ Yes ☐ No

Drug and dose: _____

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No

If so, explain with dates: _____

Does your child have any allergies or reactions to any medications? ☐ Yes ☐ No

If so, explain: _____

Does your child have any allergies to the following:

☐ pollen ☐ food ☐ food dyes ☐ dust ☐ other _____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Chronic Ear Infections	☐	☐	Hyperactivity
☐	☐	Allergies to Medication	☐	☐	Cleft Lip/Palate	☐	☐	Kidney Disease
☐	☐	Anemia	☐	☐	Convulsions/Seizures	☐	☐	Leukemia
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Mental Retardation
☐	☐	Autism	☐	☐	Emotional Disturbance	☐	☐	Nutritional Deficiency
☐	☐	Bladder Conditions	☐	☐	Epilepsy	☐	☐	Oral Ulcers
☐	☐	Blood Transfusions (Date _____)	☐	☐	Eye Problem	☐	☐	Orthopedic Problems
☐	☐	Birth Defects	☐	☐	Excessive Bleeding Problem	☐	☐	Premature Birth
☐	☐	Bone or Joint Problems	☐	☐	Excessive Gagging	☐	☐	Rheumatic Fever
☐	☐	Brain Injury	☐	☐	Faintness or Dizziness	☐	☐	Scoliosis
☐	☐	Bruising Easily	☐	☐	Growth & Development Problems	☐	☐	Sickle Cell Anemia
☐	☐	Cancer or Malignancies	☐	☐	Hearing/Speech Problems	☐	☐	Spina Bifida
☐	☐	Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Syndrome _____
☐	☐	Chronic Lung Disease	☐	☐	Hepatitis or Liver Disease	☐	☐	Tatoos
☐	☐	Chronic Adenoid/Tonsil Infection	☐	☐	Heart Disease	☐	☐	Tuberculosis
☐	☐	Chronic Headaches	☐	☐	Heart Murmur	☐	☐	Learning Disability

Please describe any current medical treatment, including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered: _____

_____

PLEASE COMPLETE REGISTRATION ON FOLLOWING PAGE.

DENTAL INFORMATION

Was your child bottle fed? ☐ Yes ☐ No If yes, until what age? _____

Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____

Has your child ever had any injuries to his teeth, mouth, head or jaws? ☐ Yes ☐ No If yes, describe _____

Does your child have a history of jaw clicking or popping? ☐ Yes ☐ No

Does your child brush daily? ☐ Yes ☐ No

Does an adult assist with the brushing? ☐ Yes ☐ No

Does your child floss daily? ☐ Yes ☐ No

Does an adult assist with the flossing? ☐ Yes ☐ No

Does your child have any of the following mouth habits? ☐ Yes ☐ No

☐ Finger Sucking ☐ Thumb Sucking ☐ Pacifier ☐ Tongue Thrusting ☐ Lip Sucking ☐ Mouth Breather ☐ Teeth Grinding

Does your child receive fluoride in any of the following forms?

☐ In Vitamins ☐ Town Water Supply ☐ In Tablets/Drops Dosage: _____ mg/day ☐ In Toothpaste ☐ In Rinse/Gel

Please check if your child has had any problems with the following:

☐ Cavities ☐ Teeth Bumped ☐ Crooked Teeth ☐ Teeth Sensitive to Hot or Cold ☐ Teeth Sensitive to Sweets

☐ Toothache ☐ Gum Infection ☐ Color of Teeth ☐ Other Dental Problems _____

How do you expect your child to react to his visit today?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

GENERAL INFORMATION

Father's Full Name _____ Mother's Full Name _____

Address _____ Phone _____ Address _____ Phone _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Social Security Number _____ Social Security Number _____

Birthdate _____ Birthdate _____

Employed by _____ Employed by _____

Bus. Address _____ Bus. Phone _____ Bus. Address _____ Bus. Phone _____

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other _____

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY CARRIER	SECONDARY CARRIER
Subscriber Name _____	Subscriber Name _____
Group/Policy Number _____	Group/Policy Number _____
Employer Name _____	Employer Name _____
Insurance Company _____	Insurance Company _____
How long have you had this insurance? _____	How long have you had this insurance? _____

EMERGENCY INFORMATION (closest relative)

Name _____

Complete Address _____ Phone _____

FINANCIAL INFORMATION, TERMS AND CONDITIONS

1. In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services.
2. I hereby authorize payment directly to Dentistry for Children of the group insurance benefits otherwise payable to me.

Parent's Signature: _____ Date: _____