

**DENTISTRY FOR CHILDREN, P.C.**  
Patient Registration and Health History

Reviewed by: \_\_\_\_\_  
For office use only

(Please complete and return on first visit. Thank you for your cooperation.)

**CHILD'S HEALTH HISTORY:**

1. Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Nickname \_\_\_\_\_  
Child's Address \_\_\_\_\_ Phone \_\_\_\_\_
2. Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Place of Birth \_\_\_\_\_
3. Child's Social Security Number \_\_\_\_\_
4. Pediatrician (name/address) \_\_\_\_\_
5. Is this your child's first visit to a dentist? \_\_\_\_\_ If child has been to a dentist before, how well was treatment accepted? \_\_\_\_\_
6. Has your child been seen by a physician during the last 12 months? \_\_\_\_\_
7. Is your child under medical care at present? \_\_\_\_\_ If so, why? \_\_\_\_\_
8. Has your child recently taken or is your child now taking any medication? \_\_\_\_\_  
\_\_\_\_\_ Recently What medication? \_\_\_\_\_  
\_\_\_\_\_ Now Why? \_\_\_\_\_
9. Has your child ever been hospitalized? \_\_\_\_\_ Why? \_\_\_\_\_ When? \_\_\_\_\_
10. Has your child ever undergone surgery? \_\_\_\_\_ Why? \_\_\_\_\_ When? \_\_\_\_\_
11. Has general anesthetic ever been administered to your child? \_\_\_\_\_  
Why? \_\_\_\_\_ When? \_\_\_\_\_ Complications? \_\_\_\_\_
12. Has your child had any of the following?  
Heart disease \_\_\_\_\_ Hepatitis \_\_\_\_\_ Bleeding disorders \_\_\_\_\_ ADHD \_\_\_\_\_  
Rheumatic fever \_\_\_\_\_ Leukemia/Tumors \_\_\_\_\_ Seizures, convulsions \_\_\_\_\_ Emotional disorder \_\_\_\_\_  
Heart murmur \_\_\_\_\_ Jaundice \_\_\_\_\_ Cerebral Palsy \_\_\_\_\_ Speech delay \_\_\_\_\_  
Asthma \_\_\_\_\_ Kidney disease \_\_\_\_\_ Congenital birth defects \_\_\_\_\_ Visual/hearing deficit \_\_\_\_\_  
Diabetes \_\_\_\_\_ HIV \_\_\_\_\_ Learning disability \_\_\_\_\_ Developmental delay \_\_\_\_\_
- Details/Other: \_\_\_\_\_
13. Has your child ever bled excessively from a cut or injury? \_\_\_\_\_
14. Has your child had any recurrent infections? \_\_\_\_\_ How often? \_\_\_\_\_
15. Has your child ever had a tooth extracted? \_\_\_\_\_ Complications? \_\_\_\_\_
16. Does your child bruise easily? \_\_\_\_\_ Has your child ever had a blood transfusion? \_\_\_\_\_
17. Does your child have any allergies? \_\_\_\_\_ Foods \_\_\_\_\_  
Medicines \_\_\_\_\_ Seasonal \_\_\_\_\_ Other \_\_\_\_\_
18. Has a physician or dentist ever warned you against giving this child any specific drug or medicine? \_\_\_\_\_ What? \_\_\_\_\_
19. Has your child ever been given penicillin? \_\_\_\_\_ Why? \_\_\_\_\_  
Any unfavorable reactions? \_\_\_\_\_
20. Has your child ever had local anesthesia? \_\_\_\_\_ Any unfavorable reactions? \_\_\_\_\_
21. How well does your child accept his/her physician? \_\_\_\_\_
22. How would you describe your child's temperament? \_\_\_\_\_
23. Does your child have any habits which might affect the mouth or teeth? \_\_\_\_\_  
Breathes through mouth \_\_\_\_\_ Tongue habit \_\_\_\_\_  
Sucks thumb or finger \_\_\_\_\_ Pacifier \_\_\_\_\_  
Bites fingernails \_\_\_\_\_ Sippy cup \_\_\_\_\_
24. Has your child ever had any injuries of the jaws or teeth? Please describe \_\_\_\_\_  
\_\_\_\_\_

25. Does your child report any pain, clicking or popping while opening mouth wide? \_\_\_\_\_
26. Does your child report any discomfort in the jaws upon awakening? \_\_\_\_\_
27. Does your child have recurrent headaches? \_\_\_\_\_ How often? \_\_\_\_\_
28. How often are your child's teeth brushed? \_\_\_\_\_ Do you help brush? \_\_\_\_\_
29. Does your child take fluoride supplements? \_\_\_\_\_ Does your child drink well water? \_\_\_\_\_  
 Does your child drink bottled water instead of town water? \_\_\_\_\_ If so, do you use bottled water for making  
 juices? \_\_\_\_\_ soups? \_\_\_\_\_ cooking? \_\_\_\_\_
30. Has your child had topical fluoride treatments? \_\_\_\_\_ Date of last treatment \_\_\_\_\_
31. Have dental X-rays ever been taken of your child? \_\_\_\_\_ Date of last X-rays \_\_\_\_\_
32. At what age did your child completely give up the bottle? \_\_\_\_\_
33. Names and birthdates of brothers and sisters \_\_\_\_\_
34. What concerns you most about your child's teeth? \_\_\_\_\_
35. Whom can we thank for telling you about our office? \_\_\_\_\_

**PARENT INFORMATION**

Father -

Mother

<b>A. Name</b>		
Home Address		
Phone		
E-mail		
Employed by		
Present Position		
Business Address		
Business Phone/Cell		
Social Security Number		
Driver's License Number	State: _____	State: _____

**B. Marital Status:** Married \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

**C. If you have dental insurance, please complete the following:**

1. Father's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Mother's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year Month Day Year

2. Name of Carrier	Policy Number	Father's Plan ✓	Mother's Plan ✓
Delta Dental			
Blue Cross/Blue Shield			
Other:			

3. I hereby authorize payment directly to Dentistry For Children, P.C. of the group insurance benefits otherwise payable to me.



\_\_\_\_\_  
Signed (insured person)

\_\_\_\_\_  
Date

**D. Master Card, Visa, American Express and Discover Card are welcome at our office. If you would like your child's dental services billed to your credit card  OR if you would like any balance remaining after dental insurance billed to your credit card , please complete the following:**

Name as it appears on card \_\_\_\_\_ Signature \_\_\_\_\_

Card# \_\_\_\_\_ CVV# \_\_\_\_\_ Expiration Date \_\_\_\_\_

**PARENT ACKNOWLEDGEMENT AND SIGNATURE**

I acknowledge that the information provided on this form is accurate and that the person who brings this child to Dentistry for Children is the legal guardian of this child. Whoever accompanies this child on subsequent visits has my express permission to consent to treatment. If this child should come for a subsequent visit unaccompanied, I hereby consent to treatment. I acknowledge that as the legal guardian, I am responsible for full payment of all charges. I understand that any balance not paid within 60 days - regardless of outstanding insurance - incurs a finance charge of 1.5% per month (18% annually) and that I will be responsible for all fees incurred in collecting any unpaid balance. I have received a copy of Dentistry for Children's Notice of Privacy Practices.



\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date