Child Registration & Health History

Child's Name_____ Date of Birth____/____/_____ Date_____

Address _____ City _____ State _____ Zip _____

Gender _____ Home # (_____)_____ Cell#(_____)_____

Child Email _____@_____ Name of School_____

Mother's Name_____

Address_____

Mother DOB__/___/___ SS#_____

Work # (_____)_____

Cell # (_____)_____

Father's Name_____

Address _____

Father DOB___/___/___SS#_____

Work # (____) _____

Cell# (____) _____

Appointment confirmation: Text to #(_____)_____ Email_____@_____

Emergency Contact Name _____Phone #(_____)_____

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

Dental Insurance Information

Name of Insured Parent _____**Date of Birth**_____/_____/_____

Insurance ID#_____ **or SS#** _____ **of Insured Parent**

Parent Employer Name and Address _____

Dental Insurance Co. _____ **Address** _____

Phone # of Insurance Co. _____ **Policy # and/or Group #** _____

Secondary Dental Coverage? YES or NO If yes, please provide information on your coverage. We will be happy to file your secondary claim for you. You are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Secondary Insurance Co. Name, Address, and Phone _____

_____

I understand that I am responsible for the cost of this care regardless of insurance coverage and deductibles. I authorize the release of information as it relates to my child's dental treatment and my insurance coverage. I also acknowledge that I have received a copy of the office "Privacy Practices" as required by the Health Insurance Portability & Accountability Act (HIPAA).

Signature _____ Date _____

Dental and Medical History

Reason for today's visit? _____ Child's last dental visit?_____ At the present time, does your child have any dental complaints or concerns? _____At home does your child drink well or bottled water?_____ Is your child currently taking a prescription fluoride supplement?_____

Previous Dentist's_____Address or phone number_____

Is your child under the care of a physician for any medical treatment? _____

Physician's Name _____ Phone #_____

Has there been any change in your child's general health in the last year? YES or NO If yes, please

Explain:_____

Has your child had any serious illnesses, operations, or been hospitalized in the last 3 years? YES or NO

If yes, please explain_____

Please check all that apply:

- ☐ **Acid Reflux**
- ☐ **ADD/ADHD**
- ☐ **Anemia**
- ☐ **Anorexia/bulimia**
- ☐ **Anxiety**
- ☐ **Asperger's Syndrome**
- ☐ **Asthma**
- ☐ **Autism**
- ☐ **Bladder/Kidney Problems**
- ☐ **Bruises Easily**
- ☐ **Cancer type_____**
- ☐ **Chicken Pox**
- ☐ **Depression**
- ☐ **Diabetes - Juvenile**
- ☐ **Drug/Alcohol Abuse**
- ☐ **Emotional Problems**
- ☐ **Epstein-Barr/Mono**
- ☐ **Frequent Fever Blisters**
- ☐ **Frequent Headaches**
- ☐ **Hearing/Speech**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **Hives/Rash**
- ☐ **HPV/STD's**
- ☐ **Liver Disease**
- ☐ **Lyme Disease**
- ☐ **Measles**
- ☐ **Mumps**
- ☐ **Mitral Valve Prolapse**
- ☐ **Pain in Jaw/Ears/TMD**
- ☐ **Psychiatric Care**
- ☐ **Rheumatic Fever**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Thyroid Disease**
- ☐ **Tonsillitis**
- ☐ **Ulcer**
- ☐ **Tuberculosis**
- ☐ **Yellow Jaundice**
- ☐ **Any other condition not listed_____**

_____

_____

ALLERGIES?

_____

_____

Medications?

_____

_____

_____

_____

I attest to the accuracy of the information on this form and hereby authorize Dr. Paper or designated staff to perform necessary dental treatment necessary for my child's dental heath mutually agreed upon by me as parent and or legal guardian

Signature _____ Date_____