Patient Registration – Child

Age _____ **Birth date** _____

Child's Name _____ **Nickname** _____ **Last Name** _____

Father's Name _____ **Mother's Name** _____

Home Address _____

City _____ **State** _____ **Zip** _____ **Home Phone** _____

Father's Occupation _____

Name of Employer _____ **Business Phone** _____

Mother's Occupation _____

Name of Employer _____ **Business Phone** _____

Person responsible for this account? Father____ Mother _____ Other _____

Is child covered by insurance plan? *Yes or No*

If yes, please answer the following:

Name of employee covered under this plan: _____

Employee Social Security Number _____ **Employee Birth date** _____

Insurance Company _____ **Group Number** _____

Indicate *Yes or No*: First visit to a dentist? *Yes or No* **An emergency** *Yes or No*

What, in your opinion, is the dental problem? _____

Is there now or has there ever been any of the following: ***(circle any which apply)***

Cavities Toothache Pain Broken Tooth

Extracted Teeth Straightened Teeth Gum Infection

Is child under care of physician now? *Yes or No* **For what reason?** _____

Name of Physician _____ **Phone** _____

Allergic to any medication or allergic to anything else? _____

Taking any medicine? *Yes or No* **Explain** _____

Has child had any history of: ***(circle any which apply)***

Anemia Emotional Problem Heart Trouble Rheumatic Fever Asthma Epilepsy

Kidney Disease Speech Impediment Convulsions Excessive Bleeding Liver Disease

Tuberculosis Diabetes Hearing Problem Mental Disturbance Tumors

Does child have any illness now? *Yes or No*

Any special problems not listed above? _____

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

Parent Signature _____ **Date** _____