PATIENT REGISTRATION – CHILD

Age ________ Birthdate ______ Sex ________

Child's Name ______________________________ SS# ______________

Father's Name ______________________ Birthdate ______________ SS# ______________

Mother's Name ______________________ Birthdate ______________ SS# ______________

Guardian's Name (If applicable) ______________ Birthdate ______________ SS# ______________

Present Address ____
Street City Zip

Present Phone ______________ Cell Phone ______________ Email ______________

Father's Occupation ______________________ Business Phone ______________

Name of Employer ______________________ City ______________

Mother's Occupation ______________________ Business Phone ______________

Name of Employer ______________________ City ______________

Do mother, father and child all live together? Yes _____ No _____

Person responsible for this account: Father ______ Mother ______ Other ______________

Is child covered by welfare, or is father or mother a member of another insurance plan?

Yes _____ No _____ If yes, please answer the following:

Name of employee covered under this plan ______________________________

His/her Social Security Number ______________ Welfare Number ______________

Has patient had pervious dental care under this program? Yes _____ No _____

Name of group dental plans ______________________________

Is this the first visit to a dentist ____________ An emergency _______ Are other family members patients here ____________

If referred by another dental office, please list dentist and date of last visit. ______________________________

____

What, in your opinion, is the dental problem ______________________________

____

Is there now or has there ever been any of the following: (Circle) Cavities Toothache Pain Broken Tooth Extracted Teeth Straightened teeth Gum Infection

Is child: Under care of physician now _____ For what ______________________________

Allergic to any medication or allergic to anything else ____________ Taking any medicine ______________

Explain above ____

Has child had any history of (Circle those that apply)

Anemia	Emotional Problem	Heart Trouble	Rheumatic Fever	Other (Please List)
Asthma	Epilepsy	Kidney Disease	Speech Impediment	
Convulsions	Excessive Bleeding	Liver Disease	Tuberculosis	
Diabetes	Hearing Problem	Mental Disturbance	Tumors	

Does child have: Any illness now ______________ Any special problem not listed above ______________

State child's interest and hobbies ______________________________

Name of physician ______________________ Phone ______________