



## Registration & Health History Form

To ensure that your child receives the best care, we ask you to carefully complete this form.

This form is completely confidential, and will be used only for dental and medical reasons.

### Tell us about your child

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  Male  Female Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
School: \_\_\_\_\_ Interests/Hobbies: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

### Person Responsible for Account

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Best phone #: (\_\_\_\_) \_\_\_\_\_  H  C  W Best phone #: (\_\_\_\_) \_\_\_\_\_  H  C  W  
Email: \_\_\_\_\_ Email: \_\_\_\_\_  
Who can legally consent for your child?  Mother  Father  Other: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

### Dental Insurance

Insurance Company: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
ID or Member #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured SS#: \_\_\_\_\_ Insured DOB: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_

**Insurance Authorization:** I authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account (such as physicians or dentists involved in my child's care or my insurance company). I authorize my insurance company to pay directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I will be responsible for all co-payments, deductibles, and any services not paid in full or in part by my insurance company.

Signature \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### Dental History

#### Previous Dental Care

Is this your child's first visit to the dentist? Y N

Previous dentist (if applicable): \_\_\_\_\_

If your child has been to the dentist previously were there any problems? Y N

If yes, please explain: \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Any injuries to the teeth, face, or mouth? Y N

If yes, please explain: \_\_\_\_\_

Family history of dental problems? Y N

If yes, please explain: \_\_\_\_\_

#### Dental care at home

When does your child brush? AM PM After meals

Do you help in brushing your child's teeth? Y N

Does your child use dental floss in cleaning their teeth? Y N

How often? \_\_\_\_\_

Is there anything else you would like to tell us regarding your child's dental health? \_\_\_\_\_

#### Primary source of drinking water:

City  Well  Bottled  Filtered/reverse osmosis

#### Has your child had any of the following forms of fluoride?

- Fluoride toothpaste  
 Fluoride rinse  
 Professional topical application  
 Fluoride supplement

#### Do any of the following apply to your child?

Frequent snacking	Y	N	Thumb/finger sucking	Y	N	
Sleeps with bottle	Y	N	Pacifier use	Y	N	
Sippy cup use	Y	N	Mouth breathing	Y	N	
Breast feeding	Y	N	Tooth grinding	Y	N	
Cups per day of:	Juice	_____	Soda	_____	Sports drinks	_____
Cups per night of:	Juice	_____	Soda	_____	Sports drinks	_____

## Medical History

Does your child have or has your child had any of the following?

(Please circle)

- Y N Health conditions requiring antibiotics or other medications prior to dental treatment
- Y N Previous hospitalization, surgery, or injury
- Y N Congenital anomalies/ Cleft Lip/Palate
- Y N Adenoid, Tonsil, or Ear Infections
- Y N Hearing, Visual, or Speech Impairments
- Y N Apnea or Snoring
- Y N Congenital Heart Defect/disease or Heart Murmur
- Y N High or Low Blood Pressure
- Y N Asthma or Reactive airway disease  
Triggers: \_\_\_\_\_  
Last attack: \_\_\_\_\_  
Hospitalizations: \_\_\_\_\_
- Y N Cystic fibrosis, Tuberculosis, or Lung problems
- Y N Dietary restrictions or Eating disorder
- Y N Gastroesophageal Acid Reflux disease
- Y N Liver disease or Hepatitis
- Y N Kidney problems or infections
- Y N Bone or Joint problems
- Y N Dermatologic conditions
- Y N Autism
- Y N Developmental disorders
- Y N Cerebral palsy
- Y N Seizures/Epilepsy or Fainting
- Y N Hydrocephaly
- Y N Emotional or Psychological problems
- Y N ADD/ADHD
- Y N Diabetes
- Y N Thyroid or Hormonal problems
- Y N Anemia or Sickle Cell disease/Trait
- Y N Bleeding problems or disorder
- Y N Cancer, Tumor, or Leukemia
- Y N HIV/AIDS
- Y N Immune disorder
- Y N Pregnancy

If "YES", please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list all medications (including over-the-counter medications, vitamins, and herbal supplements): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies/sensitivities/reactions

- Drugs or medications: \_\_\_\_\_
- Environmental (Latex, Food, Dyes, Metal, Acrylic): \_\_\_\_\_
- Anesthetics, local and general: \_\_\_\_\_
- Sedative agents: \_\_\_\_\_
- Other: \_\_\_\_\_

### Other Concerns

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical Provider

Physician name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

For Office Use

**General Treatment Consent:** I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services are rendered. I give my consent to the doctors and their staff to perform a dental exam, cleaning, and radiographs if needed for proper diagnosis. If required, I also consent to any treatment, services, medication, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_