

CHILD'S REGISTRATION FORM

Child's Name _____ Nickname _____ Date of Birth _____

Is your child covered by dental insurance _____ Medicaid _____

If yes, name of Insurance Plan & Employer _____

Insured Name _____ Insured ID # _____

Insured Date of Birth _____

Person responsible for account _____ Home Phone _____

Home Address _____ City _____ Zip Code _____

Employer _____ Business Phone _____

Father's Social Security _____ Mother's Social Security _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Reason for Child's Visit _____

Please circle "Yes" or "No". If "Yes", please give details.

Yes No Is your child nervous about dental treatment? _____

Yes No Does your child have any medical problem? Describe _____

Yes No Has child a history of cancer, heart trouble, rheumatic fever, frequent headaches, diabetes, anemia, bleeding, asthma, tuberculosis, mental disorders, hepatitis, or injury to face? If "Yes", describe _____

Yes No Has child ever been hospitalized? For what _____

Yes No Is child sensitive or allergic to anything? Describe _____

Yes No List any medication your child is presently taking _____

Yes No Is child living in an area where the water supply is fluoridated? _____

Yes No Does child have the HIV virus? _____

- Please provide my child:
- A. Best modern dentistry has to offer.
 - B. Best but on a somewhat limited budget.
 - C. Best but finances are a major concern and limiting factor.
 - D. Best but just keep me out of pain. Fear is my major concern.
 - E. Best but please get me out of pain. I'll see you the next time something hurts.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE ON MY CHILD AND WILL ASSUME RESPONSIBILITIES FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

SIGNATURE _____ DATE _____