CHILD'S REGISTRATION AND HISTORY

Date_____ Male ____
Female ____

Child's Name_____ Nickname _____
Age _____ Birthdate _____/_____/_____ School _____

Home Address _____ Phone _____
Street City State Zip

Father's Name _____ Birthdate _____ Phone _____
Address (if different) _____ SS#_____
Employer _____ Work Phone _____
Name/City Position Cell Phone _____
Mother's Name _____ Birthdate _____ Phone_____
Address (if different) _____ SS# _____
Employer _____ Work phone _____
Name/City Position Cell phone _____

Parents: Are you _____Married _____Divorced _____Separated _____Widowed _____Single

Other family members that we see: _____
Whom may we thank for referring you? _____
Nearest Friend or Relative's Name, Address, Phone: _____
_____

EMAIL ADDRESS:_____

DENTAL INSURANCE INFORMATION

_____
Subscriber's Name (primary insurance) Birthdate SS#
_____
Insurance Company Phone Employer Group #
_____
Subscriber's Name (secondary insurance) Birthdate SS#
_____
Insurance Company Phone Employer Group #

DENTAL HISTORY

What is the reason for this visit? _____

Date of last dental visit: _____ For what service? _____
Date of last cleaning: _____ Date of last dental x-rays: _____
Name of your child's former dentist: _____ Phone # _____

What is your child's attitude toward dentistry? _____

Has there been any difficulty with treatment in the past? _____ If yes, please explain:_____
_____

Have there been any injuries to head-mouth-teeth? _____
Any mouth habits (thumb-pacifier-bottle-speech-etc)? _____
Family history of missing or extra teeth? _____

Does your child brush daily? _____ How many times? _____
Do you assist your child with tooth brushing: _____ How often? _____
Is dental floss used? _____ How often? _____
Do you have well water? _____ Has it been tested for fluoride? _____
Do you filter your drinking water? _____ Has your child had fluoride? _____ Drops/tablets? _____

If there is a need: May we use local anesthetic? _____ Nitrous oxide gas? _____

MEDICAL HISTORY

Your Child's General Health (please check): _____ Excellent _____ Good _____ Fair _____ Poor

Is your child under the care of a physician at the present time? _____
If yes, what is the condition being treated? _____

Please list ALL medication NOW being taken: _____

Name of child's physician: _____
Address: _____City _____ Zip _____

Does your child have any history of rheumatic fever, heart murmur, or other heart defect? _____
If yes, please explain: _____
Are childhood vaccinations up to date?_____ Date of last tetanus:_____
Does your child have any excessive bleeding when cut? _____
Has your child ever been hospitalized or had surgery? _____
If yes, when and for what reason:_____

Does your child have any communication, emotional, genetic, mental or physical problems? _____
If yes, please explain:_____

Is your child Adopted? _____ If yes, what age? _____ Country _____

Check any of the following which your child has had or presently has:

___ ADD / ADHD
___ AIDS / ARAC / HIV
___ Allergies _____
___ Anemia
___ Aspergers
___ Asthma
___ Autism / Spectrum
___ Blood Disease
___ Blood Transfusion
___ Bruise easily
___ Cerebral Palsy
___ Chronic Cold Sores
___ Chronic Ear Infections
___ Chronic Swollen Glands
___ Diabetes
___ Epilepsy / Convulsions
___ Fainting Spells
___ Gastric Reflux
___ Heals slowly
___ Hearing Problems
___ Heart Problems
___ Hemophilia
___ Hepatitis
___ Jaw Pain
___ Malignancies or tumors
___ Mitral Valve Prolapse
___ Oral Lesions
___ Premature Birth
___ Rheumatic Fever
___ Scarlet Fever
___ Sickle Cell Disease
___ Tuberculosis (TB)
___ Ulcers or Stomach Problems
___ Unintentional Weight Loss
___ Yellow Jaundice
___ Other_____

Are there any medical problems, conditions, or diseases not mentioned above that we should be aware of:
_____

Is your child allergic or have sensitivity to any of the following:

___ Penicillin
___ Sulfa
___ Erythromycin
___ Aspirin
___ Codeine
___ Iodine
___ Nitrous Oxide
___ Local Anesthetic
___ Dental Materials
___ Latex Gloves
Other _____
Other _____

Child's Weight _____ Height _____

*** PLEASE NOTE THAT ANY CHANGES IN YOUR CHILD'S HEALTH STATUS SHOULD BE REPORTED TO OUR OFFICE AT THE EARLIEST POSSIBLE TIME ***

__WE ASK THAT YOU REMAIN IN OUR OFFICE WHILE YOUR CHILD IS TREATED__

CONSENT FOR TREATMENT

I hereby authorize Dr. Maxwell, Dr. Rastogi and Associate Dentists and their staff to complete a dental examination and take any necessary radiographs (x-rays) for my child. I further give permission for the doctors or their staff permission to perform a cleaning and apply fluoride if indicated (unless these have been done in the last 6 months). Prior to any other dental treatment such as fillings or extractions, I will be informed in advance about the details of the recommended dental services for my child. I am aware that I can remain in the treatment room with my child if I wish to do so. I assume complete responsibility for payment of all services rendered.

_____ _____
Parent / Guardian's Signature Date 04/12

We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.