

Welcome



Media System Management

Clara W. Brannan, DDS, PS
11102 Sunrise Blvd E Ste 108
Puyallup, WA 98374

Phone: (253) 848-1022, Fax: (253) 848-0218

Email: info@southhillchildrensdentistry.com or website: www.southhillchildrensdentistry.com

Registration Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or guardian who accompanies the child is responsible for payment at the time of service.

1. Tell us about your child:

Child's Name _____
Last First MI

Nickname _____ Male Female

Siblings that we treat _____

Child's Birthdate ____ / ____ / ____ Age _____

Child's home phone _____

Child's mailing address _____
street

city state zip

2. Who may we thank for referring you to our office?

3. Mother's Information:

Name _____
Last First MI

Married Single Divorced Birthdate ____ / ____ / ____

Employer _____

Home# _____ Work# _____

Cell # _____ SSN _____

Address (if different) _____

Email address _____

4. Father's Information:

Name _____
Last First MI

Married Single Divorced Birthdate ____ / ____ / ____

Employer _____

Home# _____ Work# _____

Cell # _____ SSN _____

Address (if different) _____

Email address _____

5. Consent for treatment:

Will anyone other than mom or dad bring your child into future appointments?

Name _____

Relationship to child _____

6. Consent for email or texting communication:

I understand by giving the dental practice my email and/or cell phone number that I am giving my express consent to use these as a source of communication for emails and texting unless I mark the opt-out boxes below:

Cell # _____

Email address _____

Opt-out: Email Texts

7. Primary Dental Insurance:

Insurance Co. name _____

Insurance Co. address _____

Group # (Plan, Local or Policy #) _____

Policy Owner's Name _____

Relationship to child _____

Policy Owner's birthdate ____ / ____ / ____

SSN _____

Policy Owner's Employer _____

8. Secondary Dental Insurance:

Insurance Co. name _____

Insurance Co. address _____

Group # (Plan, Local or Policy #) _____

Policy Owner's Name _____

Relationship to child _____

Policy Owner's birthdate ____ / ____ / ____

SSN _____

Policy Owner's Employer _____

Medical History

Is your child currently under the care of a physician? Yes No

If yes please explain _____

Child's Physician: _____

Physician phone#: _____ Date of last visit: _____

Address: _____

Street

City

State

Zip

Please describe your child's current physical health: Good Fair Poor

Are immunizations current? Yes No

Please list all medications your child is currently taking: _____

Is your child allergic to any foods, environmental pollutants, animals or medicines? If so please list specifics: _____

Has your child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding

Y N Cleft Palate / Lip

Y N Hepatitis Type _____

Y N AIDS/HIV+

Y N Diabetes

Y N High / Low Blood Pressure

Y N Anemia

Y N Epilepsy / Seizures

Y N Hives

Y N Any Hospital Stays/Surgeries

Y N Handicaps / Disabilities

Y N Kidney Problems

Y N Asthma

Y N Hearing / Speech

Y N Liver Problems

Y N Blood Transfusion

Y N Heart Disease

Y N Rheumatic Fever

Y N Cancer

Y N Heart Murmur

Y N Sickle Cell Anemia

Y N Cerebral Palsy

Y N Hemophilia Type _____

Y N Tuberculosis (TB)

Please discuss the above and any other medical problems your child has / had: _____

Do you consider your child to be : Progressing normally in the learning process Slow in the learning process

Dental History

What is the **primary** reason for today's visit? _____

Is your child currently having problems with any of the following?

Cavities

Toothache

Sensitive Teeth

Trauma

Gum Infection

Color of Teeth

Tooth Alignment

Other _____

Has your child experienced problems with previous dental work? Yes No Explain: _____

Is your child's home water supply fluoridated? Yes No

Does your child brush their teeth daily with fluoride toothpaste? Yes No

Do you give your child any other form of fluoride? Yes No If yes, what? _____

Does your child floss their teeth daily? Yes No

Was your child bottle or breast-fed? _____ At what age was it completely stopped? _____

Does your child suck a finger, thumb or pacifier or exhibit any other habits? _____

Previous/Present (circle) Dentist: _____ Date of last visit: _____

Why did you leave your last dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Signature _____ Date _____

Relationship to Child _____