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Child's Registration and Medical History

Your child's complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 ABOUT CHILD

Today's Date: _____

Name: _____

Nickname: _____ LAST FIRST MI Male Female

Birthdate: ____/____/____ Age: _____ SS #: _____

Home Address: _____ APT / CONDO #

_____ CITY STATE ZIP

Home #: (____) _____ Cell #: (____) _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

2 PARENT INFORMATION

Father's Name: _____

Birthdate: ____/____/____ Age: _____ SS #: _____

Employer: _____

Home #: (____) _____ Cell #: (____) _____

Work #: (____) _____ Ext: _____ DL #: _____

Mother's Name: _____

Birthdate: ____/____/____ Age: _____ SS #: _____

Employer: _____

Home #: (____) _____ Cell #: (____) _____

Work #: (____) _____ Ext: _____ DL #: _____

Person Responsible for Account:

Work #: (____) _____ Ext: _____ Home #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

ARE YOU ON MEDICAID?..... YES NO

DO YOU HAVE DSHS COUPONS?..... YES NO

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, who should be notified, other than a parent?

Name: _____ Relation: _____

Address: _____

Work #: (____) _____ Home #: (____) _____

4 MEDICAL HISTORY

Does your child have a personal physician?..... Yes No

Physician's Name: _____

Phone #: (____) _____ Date of last visit: _____

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

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY *continued*

Date of last physical: _____

Child's current physical health is:..... Good Fair Poor

Is child taking any prescription, over-the-counter, or supplement drugs?
 Yes No

Please list each one: _____

Does your child smoke or use tobacco in any other form?..... Yes No

Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Aids or Other | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Immunosuppressive Disorders | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Allergies to Medicines or Drugs | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |

Please list any serious medical condition(s) that your child has had:

Is your child allergic to any of the following?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry/Metals | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Other |

Please list any other drugs/materials that child is allergic to: _____

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

5 DENTAL HISTORY

Why have you come to the dentist today?

When was child's last dental visit? _____

Experiencing any discomfort now? _____

Do you desire complete dental service for your child? _____

Has your child ever responded adversely to medical or dental treatment?

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work?..... Yes No

Is there anything else we should know about child's dental history? _____

How many times a week does child floss? _____

How many times a day does child brush? _____

Type of bristles? Hard Medium Soft

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if credit is requested, a credit check may be required and I hereby grant Dr. Robert W. Leale this authorization.

I hereby authorize payment directly to Northview Family Dental, PLLC for the dental benefits otherwise payable to me.

Signature _____

Date _____

Relationship to child _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____