

REGISTRATION HISTORY CHILD

DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____

NICK NAME _____

SCHOOL _____ GRADE _____

FATHER'S NAME _____ HOME PHONE _____

MOTHER'S NAME _____ HOME PHONE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
(if different from father's)

FATHER EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

MOTHER EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

PURPOSE OF THIS APPOINTMENT _____

WHO WILL PAY THIS ACCOUNT _____

PARENT'S SOCIAL SECURITY NUMBER MOTHER _____ FATHER _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICE _____ YES _____ NO _____

IF SO, NAME OF COMPANY _____ POLICY NO. _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE _____ COMPANY NAME _____

SUBSCRIBER'S NAME _____ POLICY # _____

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage.)

OTHER CHILDREN IN FAMILY _____
(Names and ages)

WHOM MAY WE THANK FOR REFERRING YOUR CHILD _____

HISTORY

IS CHILD RECEIVING OTHER HEALTH CARE NOW _____ DATE OF LAST HEALTH CARE EXAMINATION _____
 NAME OF PHYSICIAN _____ PHONE NO. _____
 ADDRESS _____

HAS CHILD BEEN HOSPITALIZED IN LAST 5 YEARS _____ IF SO, FOR WHAT _____

HAS CHILD EVER HAD:

	YES	NO		YES	NO
ANEMIA	_____	_____	RHEUMATIC FEVER	_____	_____
DIABETES	_____	_____	HEART MURMUR	_____	_____
EPILEPSY	_____	_____	CHICKENPOX	_____	_____
HEPATITIS	_____	_____	MUMPS	_____	_____
ALLERGIES TO:	_____	_____	MEASLES	_____	_____
PENICILLIN	_____	_____	ABNORMAL HEART CONDITION	_____	_____
LOCAL ANESTHETIC	_____	_____	ABNORMAL BLOOD PRESSURE	_____	_____
MEDICATION OR DRUGS	_____	_____	ABNORMAL BLEEDING FROM A CUT	_____	_____
			AIDS	_____	_____
			HIV +	_____	_____

IF ALLERGIES TO MEDICATIONS OR DRUGS, INDICATE WHICH ONES _____

IS CHILD TAKING ANY MEDICATION _____ IF SO, FOR WHAT _____

OTHER PHYSICAL CONDITIONS _____

THIS INFORMATION WAS GIVEN BY _____ DATE _____

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for: _____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.

All cancellations must be given 24 hours notice unless of extreme emergency. If the appointment is not cancelled within that 24 hours, we will consider it a **BROKEN APPOINTMENT** and will therefore be charged \$25 per 30 minutes of the scheduled time.

The appointment set aside for **you** is **valuable** because we see only you in that scheduled time.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

Signature of Responsible Party _____

Relationship to Other(s) Named _____

DATE	MEDICAL UPDATE	MEDICATIONS	DATE	MEDICAL UPDATE	MEDICATIONS