PEDIATRIC DENTAL REGISTRATION AND HISTORY

Patient Information

Child Information

Child's Name _____
(First) (Middle Initial) (Last)

Preferred Name (Nickname)_____

Address _____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Date of Birth _____

SS#_____

Preferred Phone Number _____

How would you like us to confirm appointments? (Circle One)

Email Text Phone Call

Whom may we thank for referring you? _____

Mother's Information

Name _____

Date of Birth _____ SS#_____

Employer _____

Home #_____Cell#_____

Driver's License #_____

Email_____

Father's Information

Name _____

Date of Birth _____ SS#_____

Employer _____

Home #_____Cell#_____

Driver's License #_____

Email_____

Person Responsible for Account

Name _____

Relationship _____

Birth Date _____ SS#_____

Employer _____

Work #_____

Home #_____Cell#_____

Driver's License #_____

Email_____

Who has legal custody of the child? _____

Dental Insurance

Primary Insurance

Subscriber's name_____

Subscriber's SS#_____ Birth Date_____

Relationship to Patient_____

Insurance Company_____

Group#_____

Secondary Insurance

Secondary Subscriber's Name_____

Secondary Subscriber's SS#_____ Birth Date_____

Relationship to Patient_____

Insurance Company _____

Group# _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Hearthside Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also understand I will be responsible for any participating provider adjustments if co-payment is not received within the terms of said contract. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

IN CASE OF EMERGENCY, CONTACT
(Specify someone who DOES NOT live in your household)

Name _____ Home number_____

Relationship_____ Work/Cell number_____

Today's Date: _____

Dental History

Is this your child's first visit? _____

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face, or mouth?

_____

Why did you bring the child to the dentist today?

_____

How often do you brush? _____

How often do you floss? _____

Is your water fluoridated? _____

Does your child take fluoride supplements? _____

Place a mark on "yes" or "no" if the child has done or had any of the following:

Lip Sucking/ Biting?	☐Yes ☐ No
Nail Biting	☐Yes ☐No
Mouth breathing	☐ Yes ☐ No
Thumb/ Finger Sucking	☐Yes ☐ No
Foreign objects	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No
Sensitivity to cold	☐ Yes ☐ No
Sensitivity to sweets	☐ Yes ☐ No
Cheek biting	☐Yes ☐ No
Snoring	☐Yes ☐ No
Current Pacifier Use	☐Yes ☐ No

Health History

Family Physician's Name _____ Date of last visit _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Heart Problems	☐Yes ☐No	Autoimmune Disease	☐Yes ☐No	Scarlet Fever/ Rheumatic Fever	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	Asthma	☐Yes☐ No
Artificial Heart Valves	☐Yes ☐No	Cancer Type_____	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Heart Murmur	☐Yes ☐No	(Radiation or Chemotherapy)	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Blood Disease	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Abnormal Bleeding	☐Yes ☐No	AIDS/HIV	☐Yes ☐No	Fainting	☐Yes ☐No
Diabetes	☐Yes ☐No	Venereal Disease	☐Yes ☐No	Nervous Problems	☐Yes ☐No
Jaundice	☐Yes ☐No	Herpes	☐Yes ☐No	Depression	☐Yes☐ No
Hepatitis (Type ____)	☐Yes ☐No	Unexplained weight loss	☐Yes ☐No	Headaches	☐Yes☐No
ADD/ADHD	☐Yes ☐No	Eating Disorder	☐Yes ☐No	Contact Lenses?	☐Yes ☐No
Epilepsy	☐Yes ☐No	Special Diet	☐Yes ☐No	Autism/Asperger's	☐Yes ☐No
Bed Wetting	☐Yes ☐No	Learning Disability	☐Yes ☐No		

Female ONLY:

Are you pregnant	☐Yes ☐No	Taking Birth Control	☐Yes ☐No	Are you breast feeding	☐Yes ☐No

⌘List any surgeries and dates of surgeries_____

⌘List any other diagnosis not mentioned above…. _____

Allergies

_____

_____

_____

Medications

List any medications you are currently taking, whether prescribed by your physician, over the counter, or herbal supplements.

_____

_____