CHILD REGISTRATION AND MEDICAL HISTORY

Welcome

to the office of
Brian S. Kubo, DDS, Inc
(Please Print)

Date ______________

Home Phone ______________
Birthdate ______________
Age ________ Sex: ☐ M ☐ F

Child's Name ______________
Last Name | First Name | Initial | Preferred Name

Street Address / P.O. Box ______________ City ______________ State ________ Zip ________

Father's Name ______________ Social Security # ______________ Birthdate ________
Mother's Name ______________ Social Security # ______________ Birthdate ________

Father Employed by ______________ Business Phone ______________
Mother Employed by ______________ Business Phone ______________

Person Responsible for this Account? ______________ Relationship to the Patient ______________

Name of Dental Insurance Company ______________ Group # ______________
Subscriber Name ______________ Subscriber # ______________ Is There Dual Coverage ☐ Yes ☐ No

Whom Should We Call In Case Of An Emergency ? ______________ Phone Number ______________
Whom May We Thank for Referring You ? ______________

Medical History

Physician's Name ______________ Date of Last Physical ______________

Please describe your child's current physical health Good ☐ Fair ☐ Poor ☐
Has your child ever been seriously ill/hospitalized or had a surgery(s) ☐ Yes ☐ No If yes, explain: ______________
Is your child taking any medication at this time ? ________ If so, what ? ______________
Is your child under the care of any Physician at this time ☐ Yes ☐ No If yes, for what condition ______________
Please discuss any serious medical problems that the child has or may have had. ______________
Has your child ever had any drug allergies or adverse reaction to any medicine (s) ? ________ If so, what? ______________
Has your child ever responded adversely to any medical or dental treatment ? If yes, explain: ______________
What is the weight / height of your child ? Weight ______________ Height ______________
Is or has your child ever taken flouride in the form of drops or tablets? ☐ Yes ☐ No If yes, how recently? ______________

Have Your Child Ever Had the Following ? (Please Check the Boxes That Apply):

- ☐ Heart Problems
- ☐ Artificial Heart Valves or Joints
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Congenital Heart Defect
- ☐ Bleeding Problems /Anemia
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis, Jaundice
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Rheumatic /Scarlet Fever
- ☐ Epilepsy or Convulsions
- ☐ Treatment for growths/tumors
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Chronic Diarrhea
- ☐ Ulcer
- ☐ Thyroid Problems
- ☐ General allergies: dust/pollen/food/animals/other
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ Sinus Problems
- ☐ Respiratory Diseases
- ☐ Special Diet
- ☐ Recent Weight Loss
- ☐ Psychiatric Care
- ☐ Nervous Problems
- ☐ "A.I.D.S." HIV or Other Immunosuppressive Disorders
- ☐ Venereal Disease
- ☐ Chemical Dependency ie. Alcohol , etc.
- ☐ Arthritis
- ☐ Back Problems
- ☐ Circulatory Problems
- ☐ Kidney/Liver Problems
- ☐ Glaucoma
- ☐ Asthma
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Handicaps/Disabilities
- ☐ Any other condition or disease not mentioned

(Over)

Dental Questionaire

What was the name of your child's last dentist ? ____________________

Why did you bring your child to the dentist today? ____________________

How long has it been since your child has seen a dentist ? ____________________

What type of treatment was done at that time ? ____________________

Were there any complications or problems during their last dental treatment ? ____ If yes, please specify ____________________

If known, what was the date of their last X-rays ? ____________________

Are you satisfied with the appearance of your child's teeth ? ____ If no, please specify ____________________

Are any teeth sensitive to hot / cold / sweets / chewing ? ____ If yes, please specify ____________________

Do you feel that your child may have bad breath ? ☐ Yes ☐ No

Does your child's jaw frequently pop or click ? ☐ Yes ☐ No

Has your child ever complained of pain/tenderness in their jaw joint? (TMJ / TMD)? If yes, please specify ____________________

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

Thumb / Finger Sucking? ☐ Yes ☐ No Nail Biting? ☐ Yes ☐ No

Lip Sucking / Biting? ☐ Yes ☐ No Nursing Bottle Habits? ☐ Yes ☐ No

To the best of my knowledge, the noted information is accurate and will only be used in regards to my child's dental treatment, billing and processing of their dental insurance for benefits of which they are entitled. I will not hold my dentist or any member of his staff responsible for or any errors or ommisions that I may have made in the completion of this form.

Please note that our office requires at least 24 hours notice for any changes made in your appointments. Failure to do so will incur a cancellation fee of $25.00 per half hour missed.

Date ____________________ Signature ____________________

Reviewed by ____________________ Date ____________________

Informed Consent

Permission for Dental Examinations and/or Treatment of a Minor

I being the parent or guardian of ____________________ who is a minor, do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment under the general, direct, or indirect supervision of Dr. Kubo, his associates, or staff members as he may deem necessary.

This authorization will remain in effect until canceled in writing by me.

Note: Risks and Complications: Local anesthesia has risks of allergic reactions, brain damage and death. Fortunately, these damaging reactions seldom occur, however, they always exist.

Privacy of Patient Records: Please be advised that it is the policy of this office to protect the privacy rights of our patients to the fullest extent of the law. Your records will not be shared without your written consent except for our office staff, other dentists within our practice, and your designated insurance company, if applicable.

Date: ____________________

Parent or Guardian Signature: ____________________

Print Name & Relationship to Patient : ____________________

Witness Signature: ____________________

Print Name: ____________________