

## CHILD'S REGISTRATION AND HISTORY

Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_ Non-Binary \_\_\_

School \_\_\_\_\_ Sports/Hobbies: \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

Is your child Adopted? \_\_\_\_\_ If yes, what age? \_\_\_\_\_ Country \_\_\_\_\_

Guardian 1 Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Name/City Position Cell Phone \_\_\_\_\_

Guardian 2 Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address (if different) \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Name/City Position Cell phone \_\_\_\_\_

Parents: \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_ Single

Email Address: \_\_\_\_\_

Other family members that we see: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Subscriber's Name (primary insurance) Birthdate SS#

Insurance Company Phone Employer Group #

Subscriber's Name (secondary insurance) Birthdate SS#

Insurance Company Phone Employer Group #

## DENTAL HISTORY

What is the reason for this visit? \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ For what service? \_\_\_\_\_

Date of last cleaning: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Name of your child's former dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

What is your child's attitude toward dentistry? \_\_\_\_\_

Has there been any difficulty with treatment in the past? \_\_\_ If yes, please explain: \_\_\_\_\_

Have there been any injuries to head-mouth-teeth? \_\_\_\_\_

Any mouth habits (thumb-pacifier-bottle-speech-etc)? \_\_\_\_\_

Family history of missing or extra teeth? \_\_\_\_\_

Does your child brush daily? \_\_\_\_\_ How many times? \_\_\_\_\_

Do you assist your child with tooth brushing: \_\_\_\_\_ How often? \_\_\_\_\_

Is dental floss used? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have well water? \_\_\_\_\_ Has it been tested for fluoride? \_\_\_\_\_

Do you filter your drinking water? \_\_\_\_\_ Has your child had fluoride? \_\_\_\_\_ Drops/tablets? \_\_\_\_\_

If there is a need: May we use local anesthetic? \_\_\_\_\_ Nitrous oxide gas? \_\_\_\_\_

**MEDICAL HISTORY**

Your Child's General Health (please check): \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Is your child under the care of a physician at the present time? \_\_\_\_\_  
If yes, what is the condition being treated? \_\_\_\_\_

Please list ALL medication NOW being taken: \_\_\_\_\_

Name of child's physician: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Does your child have any history of rheumatic fever, heart murmur, or other heart defect? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Are childhood vaccinations up to date? \_\_\_\_\_ Date of last tetanus: \_\_\_\_\_

Does your child have any excessive bleeding when cut? \_\_\_\_\_

Has your child ever been hospitalized or had surgery? \_\_\_\_\_  
If yes, when and for what reason: \_\_\_\_\_

Does your child have any communication, emotional, genetic, mental or physical problems? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

Check any of the following which your child has had or presently has: **If nothing applies check here:** \_\_\_\_\_

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ADD / ADHD         | <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Malignancies or tumors     |
| <input type="checkbox"/> AIDS / ARAC / HIV  | <input type="checkbox"/> Chronic Swollen Glands | <input type="checkbox"/> Mitral Valve Prolapse      |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Oral Lesions               |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> Premature Birth            |
| <input type="checkbox"/> Aspergers          | <input type="checkbox"/> Fainting Spells        | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Gastric Reflux         | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Autism / Spectrum  | <input type="checkbox"/> Heals slowly           | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Hearing Problems       | <input type="checkbox"/> Tuberculosis (TB)          |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Heart Problems         | <input type="checkbox"/> Ulcers or Stomach Problems |
| <input type="checkbox"/> Bruise easily      | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Unintentional Weight Loss  |
| <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Chronic Cold Sores | <input type="checkbox"/> Jaw Pain               | <input type="checkbox"/> Other _____                |

Are there any medical problems, conditions, or diseases not mentioned above that we should be aware of? \_\_\_\_\_

Is your child allergic or have sensitivity to any of the following?  
 Penicillin       Aspirin       Nitrous Oxide       Latex Gloves  
 Sulfa       Codeine       Local Anesthetic      Other \_\_\_\_\_  
 Erythromycin       Iodine       Dental Materials      Other \_\_\_\_\_

\*\*\* PLEASE NOTE THAT ANY CHANGES IN YOUR CHILD'S HEALTH STATUS SHOULD BE REPORTED TO OUR OFFICE AT THE EARLIEST POSSIBLE TIME \*\*\*  
\*\*\*WE ASK THAT YOU REMAIN IN OUR OFFICE WHILE YOUR CHILD IS TREATED\*\*\*

**CONSENT FOR TREATMENT**

I hereby authorize Dr. Maxwell, Dr. Rastogi and Associate Dentists and their staff to complete a dental examination and take any necessary radiographs (x-rays) for my child. I further give permission for the doctors or their staff permission to perform a cleaning and apply fluoride if indicated (unless these have been done in the last 6 months). Prior to any other dental treatment such as fillings or extractions, I will be informed in advance about the details of the recommended dental services for my child. I am aware that I can remain in the treatment room with my child if I wish to do so. I assume complete responsibility for payment of all services rendered.

Parent / Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_