



CHILD REGISTRATION

Welcome to our office, we are pleased to have you here and would like to get acquainted. To better serve you, please fill out the following information for our records. *Thank you.*

Name _____ Date of Birth _____ Age _____

Address _____ City/Zip _____ Home Phone _____

E-mail Address _____

Father's Name _____ Father Employed By _____ Business Phone _____

Mother's Name _____ Mother Employed By _____ Business Phone _____

Whom may we thank for referring you to our office _____

Name of family members who are patients _____

Person financially responsible for account (not an insurance company) _____

Name of primary dental insurance company _____

Subscriber Number _____ Group Number _____ Social Security Number _____

Name of secondary dental insurance company _____

Subscriber Number _____ Group Number _____ Social Security Number _____

Primary Medical Insurance _____ Subscriber Number _____ Group Number _____

Secondary Medical Insurance _____ Subscriber Number _____ Group Number _____

In case of an emergency, whom may we contact _____

Dental/Health History

CIRCLE

- YES NO 1. Has your child been hospitalized in the past two years? If so, for what? _____
- YES NO 2. Has your child ever had any serious illnesses? _____
- YES NO 3. Is your child under the care of a medical physician at this time? If so, for what? _____
- YES NO 4. Is your child taking any prescription medications? (Please list on back)
- YES NO 5. Is your child allergic to or made sick by any of the following: Penicillin, Codeine, Latex, Sulfa drugs, Other: _____
- YES NO 6. Does your child have any other allergies? _____
- YES NO 7. Has your child's physician ever prescribed antibiotics as a pre-medication prior to dental treatment?

Circle any of the following which your child has had or is being treated for:

Heart Disease	Kidney Disease	Chemotherapy	AIDS or HIV Positive
Heart Murmur	Asthma	Leukemia	Blood Transfusion
Rheumatic Fever	Hay Fever	Cancer	Hemophilia
Scarlet Fever	Allergies/Hives	Epilepsy or Seizures	Anemia
Congenital Heart Lesions	Lung Disease	Emotional Disturbance	Jaundice
Diabetes	Bleeding Problems	Mental Disturbance	Hepatitis A
Spina Bifida	Cold Sores/Canker Sores	Mental Retardation	Hepatitis B

18. Does your child have any other disease, condition or problem not listed above? _____
19. Has your child ever received a blow or injury to his/her teeth? _____ When? _____
10. Is your child experiencing any discomfort at this time? _____
11. How often does your child brush? _____ Floss? _____
12. Is your drinking water fluoridated (i.e. city water)? _____
13. Does your child use any other form of fluoride other than that which is in your toothpaste? _____
14. Do you believe your child may have decay? _____
15. How long since your child has been to a dentist? _____ What was done then? _____
- Did he/she have x-rays? _____ If so, may we request copies? _____
- How often did he/she visit a dentist? _____

Physician's Name _____ Phone Number _____

Address _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I authorize release of any information concerning dental treatment to my benefits provider and/or any pertinent dental/medical specialists. I authorize payment directly to Mid-Valley Dental of the group insurance benefits otherwise payable to me. I agree that the charges incurred through this office for dental or surgical care for myself or my family are my responsibility. Charges that are not covered by insurance payment will be paid by me.

I consent to treatment as necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity or treatment of dental emergency. These procedures may include radiographs, models and intraoral examination. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I give my consent to the use of local anesthetic and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them at the service, unless other arrangements are made in advance.

To the best of my knowledge, all the preceding answers are true and correct. If my child ever has any change in his/her health, or his/her medicines change, I will inform the doctor, dental hygienist or dental assistant at the next appointment.

Signed (Patient, parent or legal guardian) _____ Date _____

CURRENT MEDICATIONS

REVIEW DATE

- | | | |
|----------|----------|-----------|
| 1. _____ | 1. _____ | 10. _____ |
| 2. _____ | 2. _____ | 11. _____ |
| 3. _____ | 3. _____ | 12. _____ |
| 4. _____ | 4. _____ | 13. _____ |
| 5. _____ | 5. _____ | 14. _____ |
| 6. _____ | 6. _____ | 15. _____ |
| 7. _____ | 7. _____ | 16. _____ |
| 8. _____ | 8. _____ | 17. _____ |
| 9. _____ | 9. _____ | 18. _____ |