Child Registration and Health History

Date________________

Please provide the following information so that we may best serve you. It is important to answer all questions completely. All information is confidential.

Child's Name____________________________Nickname________________________

Address________________________________City_________________Zip__________

Home Phone_________________Date of Birth_________________Age_____________

Father's name____________________Mother's Name__________________________

Father employed by___________________________Work Phone_________________

Mother employed by___________________________Work Phone________________

Person responsible for account____

Dental Insurance Coverage____

Subscriber S.S. No.____________________Subscriber D/O/B___________________

Child's Physician____

Address____Phone___________________

Whom may we thank for referring you?_____________________________________

PAYMENT POLICY: We accept the following types of payment. Please indicate the type you will be using. Balances are due in full at the time of treatment. All balances not paid within 30 days are subject to a service fee of 1.6% per month.
Cash______ Credit Card______ Check______ Citibank Financing______

Signature__________________________________

Dental History

	Yes	No
Has child complained about any dental problems	___	___
Any unhappy dental experiences	___	___
Any injuries to mouth, teeth or head	___	___
Any unusual speech habits	___	___
Any lost teeth	___	___
Orthodontic appliances worn now or previously	___	___
Does your child brush teeth daily	___	___
Do you assist child with tooth brushing	___	___
Is dental floss used	___	___
Is fluoride taken in any form	___	___

Medical History

	YES	NO
Is child under care of a physician now	____	____
Is child receiving any medications or drugs	____	____
Is there any excessive bleeding when cut	____	____
Has child ever been hospitalized	____	____
Is there any allergy to any medication or drug	____	____
Are there other allergies: food, pollen, animals, etc.	____	____

HAS CHILD HAD A HISTORY OF, OR DIFFICULTY WITH, ANY OF THE FOLLOWING:

____Anemia
____Asthma
____Bladder
____Cerebral Palsy
____Chicken Pox
____Convulsions
____Diabetes
____Epilepsy
____Fainting
____Hearing
____Heart
____Kidney
____Malignancies
____Measles
____Mononucleosis
____Mumps
____Rheumatic Fever
____Thyroid
____Tuberculosis
____HIV/AIDS
____Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or other information that the doctor should be aware of that is not mentioned above____
____

To the best of my knowledge the above is correct and complete.

Signature of Parent or Guardian________________________________ Date_________

OFFICE USE:

Summary of medical status____

Reviewed and updated_____________ Date____________________

Reviewed and updated_____________ Date____________________

Reviewed and updated_____________ Date____________________

Reviewed and updated_____________ Date____________________

CONSULTATION WITH PHYSICIAN REQUIRED YES______ NO__