Simply
Pediatric Dentistry
& Orthodontics

CHILD'S REGISTRATION AND HISTORY

Child's Name_____ Prefers to be called_____
first middle last

Sex ☐ Male ☐ Female Birthdate_____ Age___ School_____ Grade _____

Is this an emergency visit? ☐ Y ☐ N

Is this your child's first dental visit? ☐ Y ☐ N

If no, name of former dentist_____ Date of last visit_____ Purpose _____

Have any other children in your family been a patient in this office before? ☐ Y ☐ N

Reason for this visit?_____

Has your child had any bad past dental experiences? ☐ Y ☐ N Please explain_____

Names and ages of siblings:_____

Name of child's pet _____ Favorite interest _____ Favorite sport _____

Name of Parent's Dentist_____

Whom may we thank for referring you to our office?_____

GENERAL INFORMATION

Father's Full Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
S.S.#_____ Birthday_____
Employed by_____
Occupation_____
Bus. Address_____

Mother's Full Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
S.S.#_____ Birthday_____
Employed by_____
Occupation_____
Bus. Address_____

Child lives with ☐ both parents ☐ mother ☐ father ☐ other

E-mail address (for use when sending child's picture)_____

I understand that overdue balances are subject to interest and collection charges

Signature of parent _____

MEDICAL INFORMATION

Child's Pediatrician _____

Address _____ Phone _____ Date of last physical _____

	Yes	No
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Prior to receiving dental work, does your child require pre-medication?	☐	☐
Is your child being treated for any condition presently?	☐	☐
If so, please explain_____		
Is your child taking any medication or drugs?	☐	☐
If so, please explain_____		
Has your child ever been hospitalized or had surgery?	☐	☐
If so, please explain_____		
Does your child have any allergies or reaction to any medications?	☐	☐
If so, please explain_____		

Does your child have any allergies to the following?

☐ pollen ☐ food ☐ food dyes ☐ dust ☐ latex ☐ other_____

Has your child ever been diagnosed as having any of the following conditions? Please check yes(Y) or no (N):

Y	N		Y	N		Y	N	
☐	☐	AIDS or HIV	☐	☐	Cleft Lip/Palate	☐	☐	Kidney Disease
☐	☐	Anemia	☐	☐	Congenital Heart Disease	☐	☐	Leukemia
☐	☐	Asthma	☐	☐	Convulsions/Seizures	☐	☐	Mental Retardation
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Nutrional Deficiency
☐	☐	Bladder Conditions	☐	☐	Emotional Disturbance	☐	☐	Oral Ulcers
☐	☐	BloodTransfusions	☐	☐	Epilepsy	☐	☐	Orthopedic Problems
☐	☐	Birth Defects	☐	☐	Excessive Bleeding Problems	☐	☐	Premature Birth
☐	☐	Bone or Joint Problems	☐	☐	Excessive Gagging	☐	☐	Rheumatic Fever
☐	☐	Brain Injury	☐	☐	Fainting or Dizziness	☐	☐	Scoliosis
☐	☐	Bruising Easily	☐	☐	Growth & Development Problems	☐	☐	Sickle Cell Anemia
☐	☐	Cancer or Malignancies	☐	☐	Hearing/Speech Problems	☐	☐	Syndrome _____
☐	☐	Cerebral Palsy	☐	☐	Heart Murmur	☐	☐	Tuberculosis
☐	☐	Child Abuse	☐	☐	Hemophilia	☐	☐	Other _____
☐	☐	Chronic Adenoid/Tonsil Infection	☐	☐	Hepatitis or Liver Disease			_____
☐	☐	Chronic Headaches	☐	☐	Hyperactivity/A.D.D./A.D.H.D			_____
☐	☐	Chronic Ear Infections						_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been covered. _____

_____

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber's Name _____	Subscriber's Name _____
Group/Policy Number _____	Group/Policy Number _____
Employer Name _____	Employer Name _____
Insurance Company _____	Insurance Company _____
How long have you had this coverage? _____	How long have you had this coverage? _____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I authorize release of any information relating to this claim.

_____

Signature of patient (or parent if minor)

I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

_____

Signature of insured person

DENTAL INFORMATION

	Y	N	
Was your child bottle fed?	☐	☐	if yes, until what age_____
Was your child breast fed?	☐	☐	if yes, until what age_____
Has your child ever had any injuries to his teeth, mouth, head or jaws	☐	☐	if yes, please describe_____
Does your child brush daily?	☐	☐	Type of brush ☐ hard ☐ soft
Does an adult assist with the brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with the flossing?	☐	☐	

Does your child have any of the following mouth habits? ☐ finger sucking ☐ thumb sucking ☐ tongue thrusting ☐ pacifier ☐ lip sucking ☐ teeth grinder ☐ mouth breather ☐ bites nails

Does your child report any pain during chewing or while opening the mouth wide? ☐ yes ☐ no

Does your child receive flouride in any of the following forms:

☐ in vitamins ☐ in water supply ☐ in tablets/drops Dosage:_____ mg/day ☐ in toothpaste ☐ in rinse/gel

CONSENT FOR TREATMENT

I hereby authorize and direct Dr. Collins, her associates, and their dental auxiliary staff to provide dental care for my child. I understand that I will be provided with answers to any questions which may arise during the course of my child's treatment.

Patient's Name _____ Date _____

Signature of Parent or Guardian _____