



Date: _____ Patient Registration _____ Please Print

Patient's Name _____ Nickname _____ Birth Date _____ Sex _____

Patient's Address _____ Home Phone _____
 street city state zip

Email Address _____ Mobile Phone (your phone provider may charge a texting fee) _____

Father's Name _____ DOB _____ Mother's Name _____ DOB _____

Parent's Marital Status _____ Address (if different than above) _____

Father's Employer _____ Social Security # _____ Business Phone _____

Mother's Employer _____ Social Security # _____ Business Phone _____

For Patient's Covered By Insurance

Subscriber's Name _____ Birth Date _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms To _____

Group # _____ Subscriber ID # _____

Secondary Insurance

Subscriber's Name _____ Birth Date _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms To _____

Group # _____ Subscriber ID # _____

Dental History

Date of last visit to a dentist _____	Does your child brush teeth daily _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
For what service (cleaning, emergency visit, filling) _____	Do you assist child with tooth brushing _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Is dental floss used/how often _____	<input type="checkbox"/>	<input type="checkbox"/>
Date of last dental x-rays _____	Does your child take any fluoride supplementation _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Orthodontic appliances, worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child complained about dental problems, explain _____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	Any injuries to mouth - teeth - head _____	<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental experiences, explain _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Child's attitude towards dentistry _____		
Any dental habits - thumb sucking, pacifier, etc. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____		

Health History

Child's Physician _____ Address _____ Phone _____

Is your child currently under care of a physician/doctor/
dentist? explain _____

Yes No

Is your child currently under the care of a psychiatrist/
psychologist for any mental or emotional issues? explain _____

Yes No

Is your child receiving any medications or drugs (vitamins,
prescriptions, etc.) _____

Is there any excessive bleeding when cut _____

Has child ever been hospitalized, explain _____

Does your child have any allergies to drugs/antibiotics, latex,
dyes, other? explain _____

Has child ever had surgery, explain _____

Has Child Had Any History Of Or Difficulty With Any Of The Following:

- | | | | | |
|--------------------|-------------------|------------------------------|----------------------------|--------------------------|
| ___ Anemia | ___ Asthma | ___ Blood/Bleeding Disorders | ___ Bone/Joint Replacement | ___ Cancer |
| ___ Cerebral Palsy | ___ Chronic Sinus | ___ Convulsions | ___ Diabetes | ___ Ear Aches/Infections |
| ___ Fainting | ___ Hearing | ___ Heart | ___ Hepatitis | ___ HIV/AIDS |
| ___ Liver | ___ Mastoid | ___ Mononucleosis | ___ Pregnancy (teen) | ___ Rheumatic Fever |
| ___ Tobacco Use | ___ Tuberculosis | ___ OTHER: _____ | | ___ Thyroid |

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

Doctors Signature _____

May we request release of your child's medical records for our reference _____

Yes No

I hereby authorize the dentists and staff at Pediatric Dental Healthcare to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. *(Please cross out any treatment that you do not want performed.)* I authorize my insurance company to pay Pediatric Dental Healthcare all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Pediatric Dental Healthcare. This consent is to remain in effect from the date indicated until cancelled in writing.

Authorized Signature _____

Relationship To Child

Date