Child / Youth Registration

Date _____

Name of Patient _____ SS# _____
First Middle Last

Date of Birth _____ Age _____ Home # (___) _____

Father's Full Name _____ SS# _____ Work # (___) _____

Mother's Full Name _____ SS# _____ Work # (___) _____

Fax # (____) _____ E-Mail Address _____

Home Address _____ Zip _____

Past Dental Service (check): ❑ None ❑ Emergency Only (why _____) ❑ Regular ❑First Visit _____

Favorite Name or Nickname _____ Outside or Special Interest _____

School _____ School Grade _____

Person Responsible for Account _____ Relationship _____

Social Security Number _____ Occupation _____

Employer _____ Work # (___) _____

Responsible Party Employer & Address _____

Do you have Dental Insurance? Yes _____ No _____ With Whom? _____

Contact in case of Emergency _____ Relationship _____

Address _____ Zip _____ Phone # (___) _____

Recommended By _____ Patient's Physician _____

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office. Please yes or no to the following:

1. Is the patient presently under the care of a physician? ❑ **Yes** ❑ **No**
2. Has the patient ever had abnormal bleeding following a wound? ❑ **Yes** ❑ **No**
3. Is the patient allergic to ❑ **Penicillin** ❑ **Latex** ❑ **Sulfur** ❑ **Codeine** ❑ **Novocain** ❑ **Other**: _____
4. Is the patient taking any medications now ❑ **Yes** ❑ **No** If so please list: _____

5. Does the patient have any limiting disabilities? ❑ **Yes** ❑ **No** If so, what? _____
6. Has the patient ever had any of the following?

a)	**Rheumatic Fever**	❑ **Yes** ❑ **No**	**h)**	**Tuberculosis**	❑ **Yes** ❑ **No**
b)	**Rheumatic Heart Disease**	❑ **Yes** ❑ **No**	**i)**	**Diabetes**	❑ **Yes** ❑ **No**
c)	**Congenital Heart Disease**	❑ **Yes** ❑ **No**	**j)**	**Liver Trouble or Jaundice**	❑ **Yes** ❑ **No**
d)	**Blood Disorder**	❑ **Yes** ❑ **No**	**k)**	**Heart Murmur**	❑ **Yes** ❑ **No**
e)	**Epilepsy or Convulsions**	❑ **Yes** ❑ **No**	**l)**	**Hepatitis**	❑ **Yes** ❑ **No**
f)	**Asthma or Hay Fever**	❑ **Yes** ❑ **No**	**m)**	**Eczema or Hives**	❑ **Yes** ❑ **No**
g)	**Mitral Valve Prolapse**	❑ **Yes** ❑ **No**	**n)**	**HIV (Aids)**	❑ **Yes** ❑ **No**

7. Does the patient have any history of missing teeth? ❑ **Yes** ❑ **No**
8. Has the patient been under the care of a physician for any major illness or injury other than those noted above ❑ **Yes** ❑ **No**
   If so, what? _____

What concerns you most about your child's dental health?_____

_____

Does your child have any Pain in their mouth? If yes, have they had treatment? ❑ Yes ❑ No
If so Where?_____ How long?_____

When was your child's last dental exam?_____ Last Complete set of x-rays?_____

Whom may we contact to get copies of their most recent x-rays?_____

When were your child's teeth last professionally "Cleaned"?_____

Any unhappy dental experiences? ❑ Yes ❑ No

Any mouth habits: Thumb sucking, Nail biting, Mouth Breathing, Nursing bottle habits, Pacifier, Etc: ❑ Yes ❑ No

Any unusual speech habits? ❑ Yes ❑ No If yes, Please explain: _____

Are you happy with the appearance of your child's teeth? ❑ Yes ❑ No

If no, what don't you like?_____

Have you an orthodontic consultation concerning your child's teeth? ❑ Yes ❑ No

Does your child have any other dental condition of which we need to be aware? ❑ Yes ❑ No

If yes, please explain:_____

Have you ever had your child's sleep evaluated or had a sleep test? ❑ Yes ❑ No If yes, how long ago? _____

Has your child ever been told to wear Continuous Positive Airway Pressure (CPAP)? ❑ Yes ❑ No

If yes, are they currently wearing a CPAP? ❑ Yes ❑ No

Have you ever noticed that your child snores or are you aware of any snoring? ❑ Yes ❑ No

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How did you find out about our office? ❑ Relative or Spouse ❑ Drive By ❑ Internet ❑ Location
❑ Referral – Whom may we thank for referring you?_____

Would you like your child to have Nitrous Oxide (laughing gas) during treatment? (there is an additional fee for this service).
❑ Yes ❑ No

If you had to choose between the following for your child's dental care, which would you choose? (check one)
❑ Appearance ❑ Function ❑ Cost

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Would you prefer to have your child's treatment completed in a few long appointments? ❑ Yes ❑ No

Would you be available on a short notice basis for your child's appointments? ❑ Yes ❑ No

May we call your place of employment to make or confirm your child's appointments? ❑ Yes ❑ No

What can we do to make your child's dental appointment as pleasant as possible? _____

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment for the child named above in my absence.

Initial

_____ **I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices."**

_____ **I Understand That Payment Is Due at Time of Service.**

I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ OTHER

Signature: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.