MINOR/CHILD REGISTRATION

(PLEASE PRINT)

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Phone_____

PATIENT INFORMATION

Date_____

Name of Minor/Child _____
Last Name First Name Initial

Sex ☐ M ☐ F Age_____ Birthdate_____ Nickname_____ Hobbies _____

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

Person financially responsible _____ Home Phone_____ Work Phone_____

Whom may we thank for referring you?_____

PARENT / GUARDIAN INFORMATION

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone_____ (if different from above)

Employer _____

Soc. Sec.# _____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name_____

Phone No. _____

Address _____

_____

Group#_____

Policy#_____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone_____ (if different from above)

Employer _____

Soc. Sec.# _____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name_____

Phone No. _____

Address _____

_____

Group#_____

Policy#_____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance Identification# _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

DENTAL HISTORY

Date of last visit to a dentist_____ For what service _____

	YES	NO		YES	NO
Has child complained about dental problems? _____	☐	☐	Is fluoride taken in any form?_____	☐	☐
Does child brush teeth daily? _____	☐	☐	Any injuries to mouth, teeth, head? _____	☐	☐
Does child use floss every day? _____	☐	☐	Any unhappy dental experiences?_____	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc?_____				☐	☐

(OVER)

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now? _____	☐	☐	Medications at this time _____
Receiving any medication or drugs? _____	☐	☐	_____
Ever been hospitalized? _____	☐	☐	Allergies to medications: _____
Ever had surgery? _____	☐	☐	_____
Is there excessive bleeding when cut? _____	☐	☐	_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF SO PLEASE CHECK (✓)

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Chicken Pox	☐	☐	Hearing Problems	☐	☐	Measles	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Convulsions	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Heart Problems			(or MVP)	☐	☐	Thyroid Disease
☐	☐	Bladder Problems	☐	☐	Drug/Alcohol Abuse	☐	☐	Hepatitis	☐	☐	Mononucleosis	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Mumps	☐	☐	Other
☐	☐	Cerebral Palsy	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Fen-Phen or Redux			

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____

Signature of Parent/Guardian Date

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. Brian Willson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian Date

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? _____ If so, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____