DEERFIELD VALLEY Dental Care - CHILD REGISTRATION

Child's Name: _____ Parent(s) Name(s): _____

Home Phone #: _____ E-Mail Address: _____

Dad's Work #: _____ Dad's Cell #: _____

Mom's Work #: _____ Mom's Cell #: _____

Mailing Address: _____

City, State & Zip: _____

Child's Date of Birth: _____ Social Security#: _____

School Attending: _____ Preferred Pharmacy: _____

Emergency Contact (Person NOT living with child): _____

Emergency Contact Phone #: _____ Relationship to Child: _____

MEDICAL HISTORY:

Child's Physician: _____ Date of Last Visit: _____

Is your child on any prescription or over-the-counter drugs? YES ____ NO ____ If yes, please list below:

_____

Please circle any of the following your child is allergic to:

Amoxicillin Aspirin Codeine Dental Anesthetics Jewelry Latex Metals Penicillin Seaweed

List any additional allergies your child may have: _____

Please circle below any of the following your child has or has had:

ADHD	Cerebral Palsy	Fainting	HIV/AIDS	Rheumatic Fever
Anemia	Chicken Pox	Fever Blisters/Herpes	Kidney Problems	Sinus Problems
Artificial Joints	Chemotherapy	Hearing Loss	Liver Problems	Tuberculosis
Artificial Valves	Congenital Heart Defect	Heart Surgery	Mastoiditis	
Arthritis	Depression	Heart Murmur	Migraines	
Asthma	Diabetes	Hemophilia/Abnormal Bleeding	Mitral Valve Prolapse	
Bladder Issues	Difficulty Breathing	Hepatitis	Mononucleosis	
Cancer	Epilepsy/Convulsions	High/Low Blood Pressure	Mumps	

List below any additional problems/conditions you feel we should be aware of:

_____

PLEASE SEE REVERSE SIDE

Dental History:

What is your child's attitude toward dentistry? _____

Your child's current dental health is: GOOD ___ FAIR ____ POOR ___

Name of Child's Previous Dentist: _____Date of Last Visit: _____

What was done at that time? _____

Has your child ever been given dental care instruction? YES ___ NO ___

Is fluoride taken in any form? YES ___ NO ___ If yes, which? _____

Is your child currently in pain? YES ___ NO ___ Please describe: _____

_____

Any mouth habits? (thumb-sucking, nail-biting, pacifier, mouth-breathing, nursing, bottle, etc.) YES ___ NO ___

If yes, which? _____

Any injuries to mouth, teeth, or head? YES ___ NO ___ Any unusual speech habits? YES___ NO ___

How many times a day does your child brush? ____ How many times a week do they floss? ___

Do you assist? YES ___ NO ___ SOMETIMES ___ Do they use a HARD ___ MEDIUM __ or SOFT ___ brush?

Dental Insurance:

Primary Dental Insurance Company: _____ State_____

Group #: _____ Identification #: _____

Policy Holder Information:

Name: _____

Employer: _____

Date of Birth: _____Social Security #: _____

Authorization for Treatment:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any change in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child needs during diagnosis and treatment with my informed consent.

Parent or Guardian's Name: _____

Signature: _____ Date: _____