

# CHILD REGISTRATION

Today's Date: _____	Date of Birth: _____
Child's Full Name: _____	Child's Soc. Sec. #: _____
Mailing Address: _____	City: _____ State _____ Zip Code _____
Street Address: _____	Home Phone: _____
School Name: _____	Grade: _____
Child's Dental Insurance Name: _____	Number: _____
Child's Medical Insurance Name: _____	Number: _____
Child's Physician's Name: _____	Phone #: _____
Is your child now under care of physician? _____	Last Visit: _____ Reason: _____
Is this your child's first dental visit? _____	Has child ever had an unhappy dental experience? (Yes/ No)
If so, please explain? _____	Whom may we thank for referring you? _____

_____	Date of Birth: _____
<b>Father's Full Name:</b> _____	Soc. Sec #: _____
His Address: _____	Home Phone: _____
Employer: _____ How Long? _____	Business Phone: _____
Father's Medical Insurance Co.: _____	Policy # _____ Group # _____
Father's Dental Insurance Co.: _____	Policy # _____ Group # _____

_____	Date of Birth: _____
<b>Mother's Full Name:</b> _____	Soc. Sec #: _____
Her Address: _____	Home Phone: _____
Employer: _____ How Long? _____	Business Phone: _____
Mother's Medical Insurance Co.: _____	Policy # _____ Group # _____
Mother's Dental Insurance Co.: _____	Policy # _____ Group # _____

With whom does the patient live? \_\_\_\_\_

Person financially responsible: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please list other family members who are patients in this office: \_\_\_\_\_

I accept financial responsibility for all services rendered to my child. The parent or guardian bringing the child to our office is responsible for payment of the account. I authorize the release of any medical information to process my insurance claims or payment assigned to Pediatric Dentistry at Vinings or Faith N. Bates, D.M.D. This office will assist in the prompt filing of all insurance forms; however, I understand my insurance policy is a contract between me and my insurance company and I am responsible for any services not covered in my policy. In the event of default on my account, I agree to pay collection costs including attorney's fees and court costs, which may represent one-third of the balance due.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

## CHILD'S MEDICAL AND DENTAL HISTORY

**GENERAL HEALTH REVIEW** Please review your child's past and present health history. *Mark the box ONLY if your child has the condition now or has been treated for the condition in the past.*

### THE EYES, EARS, NOSE AND THROAT

- Allergies
- Chronic Earaches
- Deafness/Hearing Loss
- Speech Problems
- Chronic Sore Throat/Tonsillitis
- Tonsils/Adenoids Removed
- Blindness/Low Vision
- Other \_\_\_\_\_

### THE LUNGS

- Asthma Date of last attack \_\_\_\_\_
- Uses inhaler as needed
- Uses daily oral medicines or inhaler
- Uses steroids or has used steroids
- Bronchitis
- Pneumonia
- Tuberculosis
- Other \_\_\_\_\_

### THE CIRCULATORY SYSTEM

- Heart Murmur
- Antibiotics for previous dental work
- Circulation Problems
- Congenital Heart Problems
- Heart Surgery
- Artificial Heart Valve
- Rheumatic or Scarlet Fever
- Excessive Bleeding/Hemophilia
- Hepatitis
- Sickle Cell Anemia
- HIV/AIDS
- Leukemia
- History of Blood Transfusion Date \_\_\_\_\_
- Other \_\_\_\_\_

### THE NERVOUS SYSTEM, MUSCLES AND BONES

- Epilepsy or Seizure
- Fainting
- Cerebral Palsy
- Nervous Problems
- Mental retardation
- Down Syndrome
- Autism
- Attention Deficient Disorder
- Head Trauma/Brain Injury
- Spina Bifida
- Muscular Dystrophy
- Orthopedic Problems
- Artificial Joints
- Other \_\_\_\_\_

### THE STOMACH, LIVER, KIDNEYS, BLADDER

- Stomach Problems
- Diabetes
- Kidney Problems
- Hepatitis
- Bladder Problems
- Other \_\_\_\_\_

### ALLERGIES

- Allergy to food, food additives
- Allergy to household items, dust, pets
- Allergy to plants, pollen, grass
- Allergy to latex rubber
- Allergy to Drugs. Specify \_\_\_\_\_
- Other \_\_\_\_\_

### INFECTIONS AND SERIOUS ILLNESSES

- Immunizations are up-to-date
- Chicken Pox
- Chemotherapy Date(s) \_\_\_\_\_
- Hospitalization. Date(s) \_\_\_\_\_
- Cancer or other malignancies  
Type \_\_\_\_\_

### GROWTH AND DEVELOPMENT

- Prematurely or complicated pregnancy
- Birth defects
- Concerns with growth
- Learning, behavioral, or communication problems
- Psychological problems, testing or counseling
- Alcohol, tobacco, or drug use

### LIST ANY MEDICATIONS YOUR CHILD IS PRESENTLY TAKING

\_\_\_\_\_  
\_\_\_\_\_

CHILD'S PHYSICIAN \_\_\_\_\_ Phone # \_\_\_\_\_

### IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOUR CHILD'S HEALTH HISTORY?

\_\_\_\_\_  
\_\_\_\_\_

REVIEWED BY DR. BATES ON \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(OVER)

**DENTAL HEALTH REVIEW** Please review your child's past and present dental health for us. **Mark the box ONLY if your child has had the condition now or has been treated for the condition in the past.**

**FIRST VISIT INFORMATION (only new patients and their parents need to complete this section)**

- THIS IS MY CHILD'S FIRST DENTAL VISIT.
- MY CHILD IS WORRIED ABOUT TODAY'S VISIT
- MY CHILD'S PREVIOUS VISITS WERE UNSATISFACTORY.
- MY CHILD HAD AN ACCIDENT, HURTING THE HEAD, MOUTH, OR TEETH
- MY CHILD HAS HAD A TOOTHACHE RECENTLY  
When eating only      OR      Keeps him/her up at night (Please circle)

**DENTAL HEALTH AND HABITS. Please mark only the boxes that apply to your child.**

- MY CHILD HAS HAD REGULAR DENTAL EXAMS AND CLEANINGS
  - LAST EXAM, CLEANING AND FLUORIDE TREATMENTS (DATE \_\_\_\_\_)
  - MY CHILD PRESENTLY TAKES A FLUORIDE SUPPLEMENT
  - DENTAL X-RAYS WERE TAKEN AT EARLIER VISITS WITH DR. \_\_\_\_\_
  - MY CHILD WAS BREAST OR BOTTLE FED FOR MORE THAN 1 YEAR
  - MY CHILD SLEPT WITH A BABY BOTTLE. (What was in the bottle? \_\_\_\_\_)
  - MY CHILD SUCKS A THUMB OR FINGERS.
  - MY CHILD USES A PACIFIER
  - MY CHILD IS A MOUTH BREATHER
  - MY CHILD GRINDS or CLINCHES TEETH.
  - INJURY TO MOUTH AND/OR TEETH.
  - BLEEDING GUMS
  - ARE THERE ANY OTHER DENTAL CONCERNS TO YOU AS A PARENT?
- 
- 
- 

**WHAT IS THE FAMILY'S WATER SUPPLY**

- Well
- Public system
- Bottled/distilled

**HOW OFTEN ARE YOUR CHILD'S TEETH BRUSHED PER DAY?**

- ONCE
- TWICE
- AFTER EACH MEAL
- NONE

WHAT TYPE OF TOOTHPASTE DOES YOUR CHILD USE? \_\_\_\_\_

DO YOU HELP YOUR CHILD FLOSS DAILY? Yes or No

Thank you for your help. If there is any information you think might be of value to us in treating your child, please feel free to comment. I certify that I have read and understand the above questions. I will not hold Dr. Bates, her associates and other healthcare professionals on her staff responsible for any errors or omissions I may have made in the completion of this form.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date