

# Child's Registration form

Today's date: \_\_\_\_\_

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Male \_\_\_ Female Age \_\_\_\_\_  
Last First MI Nickname

Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Favorite Sport \_\_\_\_\_ Favorite Toy \_\_\_\_\_

Favorite Hobby \_\_\_\_\_ Favorite Character \_\_\_\_\_

Father's Name \_\_\_\_\_ Employed by \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Street City State Zip

Mother's Name \_\_\_\_\_ Employed by \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Street City State Zip

## RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

## INSURANCE INFORMATION

INSURED \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
Street City State Zip

EMPLOYER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

INSURANCE

## MEDICAL HISTORY

CHILD'S PHYSICIAN \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Is child in good health? List dental complaints: \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Is child under current medical treatment or taking any medications? (LIST) \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Does child have any allergies to medications? (LIST) \_\_\_\_\_

\_\_\_ YES \_\_\_ NO Has child experienced any unfavorable reaction to any previous dental or medical care? (EXPLAIN) \_\_\_\_\_

Check ones that apply: \_\_\_ Heart trouble \_\_\_ Epilepsy \_\_\_ Asthma \_\_\_ Rheumatic Fever \_\_\_ Diabetes  
\_\_\_ Mental Disorders \_\_\_ Heart Murmur \_\_\_ Bleeding \_\_\_ Other: \_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_