PEDIATRIC DENTAL REGISTRATION AND HISTORY

Patient Information

Child Information

Child's Name ____
(First) (Middle Initial) (Last)

Preferred Name (Nickname)________________________________

Address ____

____
City State Zip

Sex: ☐ M ☐ F Age__________ Birth Date _______________________

SS#_____________________ Cell Phone _____________________

Home Phone_____________________

Whom may we thank for referring you? ___________________________

Mother's Information

Name ______________________________________

Birth Date ________________ SS#_____________________

Employer ____

Work #____

Home #_________________Cell#_____________________

Driver's License #__________________________________

Email____

Father's Information

Name ______________________________________

Birth Date ________________ SS#_____________________

Employer ____

Work #____

Home #_________________Cell#_____________________

Driver's License #__________________________________

Email____

Person Responsible for Account

Name ____

Relationship ____

Birth Date ____________________ SS#_________________________

Employer ____

Work #____

Home #______________________Cell#__________________________

Driver's License #____

Email____

Who has legal custody of the child? _____________________________

Dental Insurance

Primary Insurance

Subscriber's name____

Subscriber's SS#_____________________ Birth Date_________________

Relationship to Patient____

Insurance Company____

Group#____

Secondary Insurance

Secondary Subscriber's Name____

Secondary Subscriber's SS#_________________ Birth Date________________

Relationship to Patient____

Insurance Company ____

Group# ____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _______________________ and assign directly to Miller Family Dentistry 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 also understand I will be responsible for any participating provider adjustments if co-payment is not received within the terms of said contract. I authorize the use of this signature on all insurance submissions.

_____________________________ _________________
Responsible Party Signature Date

IN CASE OF EMERGENCY, CONTACT
(Specify someone who DOES NOT live in your household)

Name ____________________________ Home number__________________

Relationship______________________ Work/Cell number_________________

Today's Date: ________________________________

Dental History

Is this your child's first visit? ___________________________

If not, how long since the last visit to the dentist? __________

Were any x-rays taken at previous dental visits? _________

Have there been any injuries to the teeth, face, or mouth?

____

Why did you bring the child to the dentist today?

____

How often do you brush? _____________________________

How often do you floss? _____________________________

Is your water fluoridated? _____________________________

Does your child take fluoride supplements? ______________

Place a mark on "yes" or "no" if the child has done or had any of the following:

Lip Sucking/ Biting?	☐Yes ☐ No
Nail Biting	☐Yes ☐No
Mouth breathing	☐ Yes ☐ No
Thumb/ Finger Sucking	☐Yes ☐ No
Foreign objects	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No
Sensitivity to cold	☐ Yes ☐ No
Sensitivity to sweets	☐ Yes ☐ No
Cheek biting	☐Yes ☐ No
Snoring	☐Yes ☐ No
Current Pacifier Use	☐Yes ☐ No

Health History

Family Physician's Name ____ Date of last visit ____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Heart Problems	☐Yes ☐No	Autoimmune Disease	☐Yes ☐No	Scarlet Fever/ Rheumatic Fever	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Thyroid Problems	☐Yes ☐No	Asthma	☐Yes☐ No
Artificial Heart Valves	☐Yes ☐No	Cancer Type__________________	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Heart Murmur	☐Yes ☐No	(Radiation or Chemotherapy)	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Blood Disease	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Abnormal Bleeding	☐Yes ☐No	AIDS/HIV	☐Yes ☐No	Fainting	☐Yes ☐No
Diabetes	☐Yes ☐No	Venereal Disease	☐Yes ☐No	Nervous Problems	☐Yes ☐No
Jaundice	☐Yes ☐No	Herpes	☐Yes ☐No	Depression	☐Yes☐ No
Hepatitis (Type ____)	☐Yes ☐No	Unexplained weight loss	☐Yes ☐No	Headaches	☐Yes☐No
ADD/ADHD	☐Yes ☐No	Eating Disorder	☐Yes ☐No	Contact Lenses?	☐Yes ☐No
Epilepsy	☐Yes ☐No	Special Diet	☐Yes ☐No	Autism/Asperger's	☐Yes ☐No
Bed Wetting	☐Yes ☐No	Learning Disability	☐Yes ☐No		

Female ONLY:

Are you pregnant	☐Yes ☐No	Taking Birth Control	☐Yes ☐No	Are you breast feeding	☐Yes ☐No

⌘List any surgeries and dates of surgeries____

⌘List any other diagnosis not mentioned above…. ____

Allergies

____

____

____

Medications

List any medications you are currently taking, whether prescribed by your physician, over the counter, or herbal supplements.

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