



Committed to delivering high-quality care.

### CHILD Registration Form

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Last Name First MI Preferred Name

**Home Address:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Name of School Attending:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Father's Name:** \_\_\_\_\_

**Contact #'s Home:** \_\_\_\_\_ **Best time to call:** \_\_\_\_\_

**Names of immediate family members:** \_\_\_\_\_

**Nearest Relative:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Perferred Appointment Times:**  Morning  Afternoon  Evening  Anytime  M  T  W  TH  F  S

**Email Address:** \_\_\_\_\_

### Health Information

**Previous Dentist:** \_\_\_\_\_ **Date of Last Dental Visit:** \_\_\_\_\_

**Reason for this visit:** \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths               | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries         | Due Date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis Type:       | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Sinus Problems       |   |
|  | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Stomach Problems     |   |

**Please list all medications you are now taking:** \_\_\_\_\_

**Have you ever had any complications following dental treatment?**  Yes  No

If yes, please explain: \_\_\_\_\_

**Have you ever been admitted to a hospital or needed emergency care during the past two years?**  Yes  No

If yes, please explain: \_\_\_\_\_

**Are you now under the care of a physician?**  Yes  No

If yes, please explain: \_\_\_\_\_

**Name of Physician:** \_\_\_\_\_

**Do you have any health problems that need further clarification?**  Yes  No

If yes, please explain: \_\_\_\_\_

**Whom may we thank for referring you to our practice?** \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the doctors at the next appointment without fail.**

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date