



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