REGISTRATION AND HISTORY

Central CT Pediatric Dentistry and Orthodontics

Date: _____

Patient Name: _____ M/F Nick Name: _____ Age: _____ DOB: _____

Residence Address: _____City _____State _____Zip _____

Brother's/Sister's
Names and Ages: _____ Favorite Hobby/Toy_____Present Weight _____

School _____Grade _____ Pet _____

ACCOUNT INFORMATION

FATHER'S NAME: _____

ADDRESS: _____

PHONE (HOME): _____(WORK): _____

CELL: _____

EMAIL ADDRESS: _____

EMPLOYER/DIVISION: _____

ADDRESS: _____

DENTAL INS. CO. _____

INS. ADDRESS: _____

POLICY # _____

SOCIAL SECURITY # _____

DATE OF BIRTH: _____

MOTHER'S NAME: _____

ADDRESS: _____

PHONE (HOME): _____(WORK): _____

CELL: _____

EMAIL ADDRESS: _____

EMPLOYER/DIVISION: _____

ADDRESS: _____

DENTAL INS. CO. _____

INS. ADDRESS: _____

POLICY # _____

SOCIAL SECURITY # _____

DATE OF BIRTH: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DENTAL HISTORY

Reason for visit: ☐ Routine Care ☐ Orthodontic Care

Specific Concerns: _____

Is this the first dental visit? (Yes or No) _____

If No, previous dentist's name/address: _____

_____

Date of last visit: _____

	YES	NO
Has child complained about dental problems?	☐	☐
Any unhappy dental experiences?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any mouth habits - thumbsucking, nail biting, sippy cup, mouth breathing, nursing bottle habits, pacifier, etc	☐	☐
Does child snore?	☐	☐
Any unusual speech habits?	☐	☐
Any lost teeth?	☐	☐
Do you desire complete dental service for the child?	☐	☐

	YES	NO
Have missing teeth been replaced?	☐	☐
Orthodontic appliances, worn now or ever?	☐	☐
Parents ever wear braces?	☐	☐
Does your child brush daily?	☐	☐
Does your child use toothpaste?	☐	☐
Do you assist child with toothbrushing?	☐	☐
How often? _____		
Is dental floss used?	☐	☐
How often? _____		
Family history of gum disease?	☐	☐
Parents' history of dental decay?	☐	☐
Is fluoride taken in any form?	☐	☐
Child's attitude to dentistry_____		
Parents' attitude toward dentistry _____		

PLEASE COMPLETE REVERSE SIDE ALSO

MEDICAL AND HEALTH HISTORY

Child's Physician: _____Address _____Telephone _____

Last date of physical exam _____ Results _____

	YES	NO		YES	NO
1. Is child under the care of a physician now?	☐	☐	7. Any other allergies?	☐	☐
Name of Dr. _____			a. Drugs, Penicillin, etc_____		
Reason: _____			b. Food, peanuts, pollen, dust, other:_____		
2. Is child receiving any medication or drugs? ____	☐	☐	8. Does child have good physical coordination?	☐	☐
_____			9. Are there any physical problems?_____	☐	☐
3. Is there excessive bleeding when cut? _____	☐	☐	_____		
_____			10. Any learning difficulties? _____	☐	☐
4. Has child ever been hospitalized?_____	☐	☐	_____		
_____			11. Does child get upset easily? _____	☐	☐
5. Has child ever had surgery? Age: _____	☐	☐	12. Any problems at birth/before birth? _____	☐	☐
Reason: _____			_____		
6. Is your child or any family member allergic to latex?	☐	☐	13. Are immunizations current?	☐	☐
_____					

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia	___ Convulsions	___ HIV	___ Mononucleosis	___ Mumps
___ Asthma	___ Diabetes	___ Hearing	___ Kidney	___ Rheumatic Fever
___ Bladder	___ Epilepsy	___ Heart	___ Liver	___ Thyroid
___ Cerebral Palsy	___ Fainting	___ Heart Murmur	___ Malignancies	___ Transfusions
___ Chicken Pox	___ Hernia	___ Hepatitis	___ Mastoid	___ Tuberculosis
___ Chronic Sinus	___ Frequent Infections	___ High Fever	___ Measles	___ Other

Please describe any current or past medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of:

_____

_____

May we request release of your child's medical records for our reference? ☐ **YES** ☐ **NO**

SUMMARY: (for doctor's use)

PERMIT FOR TREATMENT UPON A MINOR

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status.

I, being the parent or guardian of the above minor patient, have the authorization and do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics, which may be deemed advisable by the Doctor.

I will be informed of all services and their charges by this office before any of the services are rendered.

Furthermore, I understand as the parent or guardian I will be responsible for all financial obligations incurred on this child for dental treatment whether or not I accompany this child to the office visit. There will be a 1-1/2% monthly finance charge for all accounts 60 days or more past due. Should this account be referred to a collection agency for non-payment all collection and attorneys' fees will be the responsibility of the debtor.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: _____

(Signature of Parent/Guardian and Relationship to Child)

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