• Spencer & Kerby •
Comprehensive Dentistry

Child Registration and History

Date: _____

1. About Your Child

Child's Name: _____
LAST FIRST MI

Preferred Name: _____

Gender: M/F Birthdate: _____ Age: _____

SSN: _____ Home Phone: _____

Child's Address: _____

_____
CITY STATE ZIP

School: _____ Grade: _____

Hobbies/Interests: _____

2. Insurance Information

Please give insurance card to office on your first visit or if your insurance has changed.

PRIMARY DENTAL INSURANCE

Ins. Company: _____ Group #: _____

Primary Insurance Holder: _____

Relation to Patient: _____

SSN: _____ Birthdate: _____

Employer: _____

SECONDARY DENTAL INSURANCE

Ins. Company: _____ Group #: _____

Secondary Insurance Holder: _____

Relation to Patient: _____

SSN: _____ Birthdate: _____

Employer: _____

3. Child's Family Information

Who is financially responsible for the account? _____

ABOUT THE MOTHER

Name: _____
LAST FIRST MI

Birthdate: _____ SSN: _____

Address: ☐ Check if same as child's _____

_____
CITY STATE ZIP

Email: _____

Home Phone: ☐ Check if same as child's _____

Work Phone: _____ Cell Phone: _____

Employer: _____

ABOUT THE FATHER

Name: _____
LAST FIRST MI

Birthdate: _____ SSN: _____

Address: ☐ Check if same as child's _____

_____
CITY STATE ZIP

Email: _____

Home Phone: ☐ Check if same as child's _____

Work Phone: _____ Cell Phone: _____

Employer: _____

4. Dental Information

Date of Last Dental Appt.: _____

1. Y N Has child complained about dental problems? _____
2. Y N Any injuries to mouth/head/teeth? _____
3. Y N Lost any teeth? _____
4. Y N Have missing teeth been replaced? _____
5. Y N Have orthodontic appliances ever been worn? _____

For What Service: _____

6. Y N Does child require pre-medication? _____
7. How many times a day does the child brush? _____
8. How many times per week does the child floss? _____
9. Child's attitude towards dentistry: _____

_____

Please continue on back

5. Medical History

Current or previous health problems as well as any medications that your child is taking could have an important interrelationship with the dental care they will receive. Thank you for answering the following questions.

Child's Physician: _____ **Phone:** _____

Date of Last Medical Exam: _____ **Address:** _____
CITY STATE ZIP

1. Y N Is child under care of physician now? For what? _____
2. Y N Is child taking any medication or drugs? Please list: _____
3. Y N Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.? (Circle) _____
4. Y N Any unusual speech habits? _____
5. Y N Is there any excess bleeding when cut? _____
6. Y N Has child ever been hospitalized? For what? _____
7. Y N Has child ever had surgery? For what? _____
8. Y N Does child have good physical coordination? _____
9. Y N Are there any emotional problems? _____
10. Y N **Does child have any of the following allergies:** ☐ Latex ☐ Penicillin/Amoxicillin ☐ Dental Anesthetics (Novocaine) ☐ Tetracycline ☐ Aspirin ☐ Food Allergies ☐ Other(s): _____
11. Y N Has the child ever had history of or difficulty with any of the following? Check all that apply.

☐ Anemia	☐ Epilepsy	☐ Jaw Problems JMJ/TMD	☐ Rheumatic Fever
☐ Asthma	☐ Fainting	☐ Kidney	☐ Thyroid
☐ Bladder	☐ Hearing	☐ Leukemia	☐ Tonsillitis
☐ Cerebral Palsy	☐ Heart	☐ Liver	☐ Tuberculosis
☐ Chicken Pox	☐ Hepatitis	☐ Malignancies	☐ Venereal Disease
☐ Cleft Lip/Palate	☐ High/Low Blood Pressure	☐ Measles	☐ Other
☐ Convulsions	☐ HIV+/AIDS/ARC	☐ Mononucleosis	
☐ Diabetes/Hypoglycemia	☐ Hyperactive/ADD	☐ Mumps	

12. Y N Does child have any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed? _____

Please Read and Sign Below

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

1. Payment for all services rendered is required at the time of each visit, unless other arrangements have been made with the office manager (i.e. estimate insurance payment). If account is not paid within 90 days of the date of service and no arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.
2. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
3. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____ Relationship to Patient: _____