CHILD REGISTRATION AND HISTORY

(PLEASE PRINT)

CHILD'S NAME:_____PREFERRED NAME:_____

ADDRESS (City/Sate/Zip) :_____

PHONE #:_____ BIRTHDATE:_____ GENDER: M / F

GUARDIAN INFORMATION:

FULL NAME/RELATIONSHIP:_____E-MAIL:_____

ADDRESS (City/Sate/Zip) :_____

HOME PHONE:_____ CELL PHONE:_____

BIRTHDATE:_____ SOCIAL SECURITY #:_____

PLACE OF EMPLOYMENT:_____ WORK PHONE:_____

DENTAL INSURANCE (Please provide copy of insurance card): _____

EMERGENCY CONTACT IF YOU CANNOT BE REACHED:

NAME/RELATION TO PATIENT:_____CELL PHONE:_____

PERSON FINANCIALLY RESPONSIBLE/RELATIONSHIP TO CHILD:_____

ADDRESS (City/Sate/Zip) :_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

MEDICAL HISTORY

PHYSICIAN'S NAME:_____ PHONE NUMBER:_____

IS YOUR CHILD TAKING ANY MEDICATIONS? IF YES, PLEASE LIST: _____ _____

IS THE CHILD ALLERGIC TO ANY MEDICATIONS? IF YES, TO WHAT:_____

HAS THE CHILD HAD ANY HISTORY OF (OR DIFFICULTY WITH) ANY OF THE FOLLOWING:

___Allergies	___Craniofacial	___Hearing	___Liver Disorder	___Seizures
___Arthritis	___Diabetes	___Heart	___Malignancies	___Stroke
___Asthma	___Developmental Delays	___Hepatitis	___Measles/Mumps	___Thyroid Disorder
___Autism	___Ears (Tubes)	___Immunodeficiency	___Mononucleosis	___Tuberculosis
___Bleeding Disorder	___Fainting	___Jaundice	___Orthopedic	___ Ulcers/Colitis
___Cerebral Palsy	___Fever (High >104)	___Kidney Disorder	___Premature Birth	___Other:_____
___Chronic Sinusitis	___Gastrointestinal	___Leukemia	___Rheumatic Fever	_____

IS THERE ANY OTHER MEDICAL CONDITION NOT LISTED THAT WE NEED TO KNOW ABOUT? IF YES, PLEASE EXPLAIN:

_____

DENTAL HISTORY

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____

DATE OF LAST DENTAL EXAM?_____WHAT WAS DONE?_____

HAS THE CHILD EVER HAD A BAD DENTAL EXPERIENCE? IF YES, PLEASE EXPLAIN:_____

_____

HAS THE CHILD EVER SUFFERED ANY INJURIES TO THE MOUTH, HEAD OR TEETH? IF YES, PLEASE EXPLAIN:_____

_____

WHAT TYPE OF WATER DOES THE CHILD DRINK? ___City Water ___Well Water ___Bottled Water

HOW WOULD YOU RATE THE CHILD'S DENTAL HYGIENE? ___Excellent ___Good ___Poor

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

___ Bad Breath

___ Bleeding Gums

___ Blisters on lips or mouth

___ Complications from Extractions

___ Dental Floss

___ Fluoride Rinse or Supplements

___ Food Impaction

___ Frequency of Brushing: _____

___ Grinding or Clenching of Teeth

___ Mouth Breather

___ Oral Habits (thumbsucking, pacifier)

___ Orthodontics

___ Pain around ear(s)

___ Sensitive Teeth (hot, cold, sweets)

___ Snacks between meals

___ Snoring

___ Swelling or lumps in the mouth

___ Well Balanced Diet

IS THERE ANY OTHER DENTAL CONDITION NOT LISTED ABOVE THAT WE NEED TO BE AWARE OF OR IS THERE ANYTHING YOU WOULD LIKE FOR US TO DISCUSS WITH YOUR CHILD?_____

_____

CONSENT FOR TREATMENT

Both the doctor and patient/guardian are encouraged to discuss any and all relevant patient health issues prior to treatment.

Your child is a minor, therefore it is necessary that a signed permission be obtained from a parent or guardian before any dental services can begin . I grant Crawfordsville Family Dentistry permission to provide my child with any necessary dental care. If I have dental insurance, I understand that I will be responsible for the total cost of treatment that my insurance does not pay. Furthermore, I certify that I have completed this form to the best of my knowledge. I will not hold Dr. Scott Frey or any other member of Crawfordsville Family Dentistry responsible for any action they take or do not take because of any omissions that I may have made in the completion of this form. I understand that the information I provide is essential to determine my child's dental treatment. I also understand that if any changes occur in my child's health, I will advise the dental office as soon as reasonably possible.

PARENT/GUARDIAN SIGNATURE_____ DATE:_____

DENTIST SIGNATURE:_____ DATE:_____