Dental Health Associates of Streetsboro — CHILD REGISTRATION

PATIENT INFORMATION

Child's Full Name: ______________________ ☐ Female ☐ Male

Birthday: ______________ Home Phone: (______) ______________

Street Address: ______________________ Apt. Number ________

City: ______________ State: __________ Zip Code: __________

How did you hear about our office? ______________________

PARENT INFORMATION

Father's Name: ______________________

Street Address: ______________________ Same as Above ☐

Home Phone: (______) ______________________ Same as Above ☐

Father Employed By: ______________ Work Phone Number: (______) __________

Mother's Name: ______________________

Street Address: ______________________ Same as Above ☐

Home Phone: (______) ______________________ Same as Above ☐

Mother Employed By: ______________ Work Phone Number: (______) __________

Is your Child covered by Dental Insurance? ☐ Yes ☐ No

PRIMARY INSURANCE

Name of Primary Insurance Company: ______________________

Address of Insurance: ______________________

City: ______________ State: __________ Zip Code: __________

Insurance Phone Number: (______) __________ Group/Plan Number: __________

Name of Policy Holder: ______________ Policy Holder's Birthday: __________

Policy Holder's Social Security Number: ______________

SECONDARY INSURANCE

Name of Secondary Insurance Company: ______________________

Address of Insurance: ______________________

City: ______________ State: __________ Zip Code: __________

Insurance Phone Number: (______) __________ Group/Plan Number: __________

Name of Policy Holder: ______________ Policy Holder's Birthday: __________

Policy Holder's Social Security Number: ______________

OTHER INFORMATION

Person financially responsible if other than parent: ______________________

Relationship to Child: __________ Address of Insurance: ______________________

City: ______________ State: __________ Zip Code: __________

Dental Health Associates OF STREETSBORO

DENTAL & HEALTH HISTORY

DENTAL HISTORY

Date of last visit to dentist ____________________

Type of appointment ____________________

	YES	NO
Any dental concerns?	☐	☐
If YES, what? ____________________		
Any unhappy dental experiences?	☐	☐
Any injuries to mouth/teeth/head?	☐	☐
If YES, what? ____________________		
Any mouth habits – thumbsucking, mouth breathing, nail biting, nursing bottle habits, pacifier, etc.?	☐	☐
Any unusual speech habits?	☐	☐
If YES, what? ____________________		
Any lost teeth (baby or otherwise)?	☐	☐
Have lost teeth been replaced?	☐	☐
Are Orthodontic appliances being worn now or in the past?	☐	☐
Does your child brush teeth daily?	☐	☐
Do you assist child with brushing?	☐	☐
How often? ____________________		
Is fluoride taken in any form?	☐	☐

Child's attitude to dentistry ____________________

HEALTH HISTORY

Child's Physician ____________________

Address ____________________

Phone # (_______) ____________________

Date of last physical ____________________

	YES	NO
Is child under care of physician now?	☐	☐
Is child receiving any medication?	☐	☐
If YES, what? ____________________		
Is there excessive bleeding when cut?	☐	☐
Has child ever been hospitalized?	☐	☐
Has child ever had surgery?	☐	☐
Is there any allergy to penicillin or other drugs?	☐	☐
If YES, what? ____________________		
Are there any other allergies: food, animals, pollen, dust, etc.?	☐	☐
Does your child have good physical coordination?	☐	☐
Are there any emotional problems?	☐	☐

ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING?

☐ Anemia	☐ Asthma
☐ Bladder	☐ Cerebral Palsy
☐ Chicken Pox	☐ Chronic Sinus
☐ Diabetes	☐ Epilepsy
☐ Fainting	☐ Hearing
☐ Heart	☐ Hereditary Habits
☐ Kidney	☐ Liver
☐ Malignancies	☐ Mastoid
☐ Measles	☐ Mononucleosis
☐ Mumps	☐ Rheumatic Fever
☐ Thyroid	☐ Tuberculosis
☐ Other ____________________	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that was not mentioned above: ____________________

This information was discussed with and given by ____________________

Relation to child ____________________ Date ____________________