Welcome! Child Registration Form

Thank you for choosing our office for your child's dental needs. We are committed to helping your family maintain good dental health. Please fill out this form and return it to our office prior to your child's first visit. This form will help us to get to know your child better and will be kept confidential. If you have any questions or concerns, please ask. We will be happy to help. (Please Print)

Patient Information

Name_____Birthdate _____ Gender: M / F

Nickname _____ Age _____ Child lives with _____

Home Address_____ City_____State/Zip_____

Guardian 1 Information

Name _____ Relationship to child _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Home #_____ Work #_____ Cell #_____

Email (for appointment communication, newsletters, etc) _____

Guardian 2 Information

Name _____ Relationship to child _____

Address (if different than child's) _____

City _____ State _____ Zip _____

Home #_____ Work #_____ Cell #_____

Email (for appointment communication, newsletters, etc) _____

Appointments

Which Guardian shall we contact to schedule appointments? _____

Do you prefer to receive appointment confirmations via (circle one): Email Text Message Home Phone

Who will be accompanying your child to the dental appointments? _____

Guardian's Signature_____Date_____

Financials Regarding a Minor

Responsible Party

Who is responsible for payment? _____Relationship to child_____

If responsible party is not listed on the front page, please complete this section:

Address _____

City _____ State _____ Zip _____

Home #_____ Work #_____ Cell #_____

Email (for appointment communication, newsletters, etc) _____

I understand that payment is due on or before date of treatment, depending on the appointment. I understand that any balance overdue may be subject to a 10% APR finance charge and agree to the terms as described in the office guide.

Guardian's Signature_____Date_____

Is the child covered under Dental Insurance □ YES □ NO

Name of Insured_____Relationship to patient_____

Birthdate_____ Insurance Co._____Insurance ID #_____

Name of employer_____Work #_____

Address_____City_____State/Zip_____

Insur Co. Address_____City_____State/Zip_____

How much is your annual deductible?_____Coverage period_____Max. Annual benfit_____

Is there Secondary Dental Insurance □ YES □ NO

Name of Insured_____ Relationship to patient_____

Birthdate_____ Insurance Co._____Insurance ID #_____

Name of employer_____Work #_____

Address_____City_____State/Zip_____

Insur Co. Address_____City_____State/Zip_____

How much is your annual deductible?_____Coverage period_____Max. Annual benfit_____

I authorize and request that my insurance company pay directly to the dental office any insurance benefits otherwise payable to me. I understand that my dental benefits may not cover the entire bill for services. I accept personal responsibility for the balance of any fee where a service is only partially covered by the insurance company. I understand that my balance may be due prior to receiving the insurance payment, as described in the office guide. I understand that any balance overdue may be subject to a 10% APR finance charge and agree to the terms as described in the office guide.

Guardian's Signature_____Date_____

Child's Medical History

Name:_____Date of Birth:_____ Gender: M / F Weight_____

Primary Care Physician_____Date of last visit_____

Physician's Address_____Phone #_____

Is the child under the care of a specialist? Yes / No Type_____

Specialist name_____Phone #_____

Address_____City_____State/Zip_____

Please check any of the following that your child has now or has experienced in the past:

□ Acid Reflex/GERD
□ ADHD
□ Allergies (list on next pg)
□ Anemia
□ Arthritis/Rheumatism
□ Artificial Heart Valves
□ Artificial Joints:
*Type:*_____
*Date:*_____
□ Asthma
□ Autism
□ Back Problems
□ Blood/Bleeding Disorders
*Describe:*_____
□ Blood Transfusion
*Date:*_____
□ Cancer: *Site*_____
□ Chemotherapy
Date Completed:_____
□ Circulatory Problems
□ Cortisone Treatment
□ Cough, Persistent
□ Cough up blood
□ Diabetes
*Type:*_____
□ Eating Disorder
Specify:_____
□ Epilepsy
□ Fainting
□ Headaches
□ Heart Murmur
□ Heart Problems
*Describe:*_____
□ Hepatitis: *Which*:_____
□ Exposure to Hepatitis
□ Herpes Virus/Cold Sores
□ HIV Positive/AIDS
□ Exposure to HIV/AIDS
□ Kidney Problems
□ Latex Allergy
□ Liver Problems
□ Mitral Valve Prolapse
□ Measles
□ Mumps
□ Nervous System Problems
□ Psychiatric Care
□ Radiation Therapy
Date Completed:_____
□ Respiratory Problems
*Describe:*_____
□ Rheumatic Fever
□ Scarlet Fever
□ Sinus Trouble
□ Skin Rash
□ Skin Reaction to Metals
*Describe:*_____
□ Sleep Apnea
□ Steroid Use: *Describe:*_____
□ Stroke
□ Surgeries
*Describe:*_____
□ Thyroid Problems: *Which:*_____
□ Tobacco User
*Type and how much:*_____
□ Tonsillitis
□ Tonsils Removed
□ Tuberculosis
□ Ulcer
□ Other_____

Anything else we need to know about your child?

Please describe:_____

Does anyone in the child's immediate family have a history of any the above listed conditions?

Please describe:_____

Child's Medications

Is your child taking or has recently taken any medicine(s) including over-the-counter, non-prescription and herbal medications? Yes No If **yes**, list below:

Herbal Medications: check box

Aloe ☐	Coenzyme10 ☐	Echinacea ☐	Ephedra ☐
Garlic ☐	Gingko Biloba ☐	Ginseng ☐	Goldenseal ☐
Hawthorne ☐	Kava-Kava ☐	Melatonin ☐	Licorice Root ☐
Saw Palmetto ☐	St John's Wort ☐	Valerian ☐	Yohimbe ☐

Prescription and Non-Prescription Medications:

Medical Condition	Medication	Dosage

Drug Allergies:_____

Other Allergies:_____

I certify that the above information is accurate and correct. I understand that providing incorrect or incomplete health information can be dangerous and compromise my child's dental treatment. I also understand that this information will be held in the strictest of confidence and will only be released to relevant health professionals as needed to treatment. It is my responsibility to update this medical information as changes occur in the future.

Guardian's Signature_____ Date_____

Child's Medical History Update

I have reviewed the above information and have updated it as needed.

Date	Guardian's Initials	Clinician's Initials	Date	Guardian's Initials	Clinician's Initials

Child's Dental History

Name_____ Birthdate_____Age_____

Previous Dentist_____ State/Zip_____

Date of last visit_____What was done_____ Date of last radiographs/films_____

Reason for today's visit_____

How often does your child brush?_____ How often does your child floss?_____ Use a Fluoride rinse? Yes / No

Does the toothpaste used contain Fluoride? Yes / No Does the parent/guardian brush or floss the child's teeth? Yes / No

List any other dental devices, aids, or products that are used:_____

Is the child taking Fluoride drops/tablets? Yes / No Is the drinking water fluoridated at home? Yes / No

Does the child participate in a Fluoride program at school? Yes / No How often? _____

Please check any of the following that your child has now or has experienced in the past:

☐Bad Breath	☐Dry mouth	☐Pain from a tooth
☐Bad taste in mouth	☐Food catching between teeth	☐Periodontal surgery
☐Bleeding gums	☐Grinding teeth	☐Sensitivity to hot, cold, or biting
☐Blisters on lips or mouth	☐Loose teeth	☐Swelling or lumps in mouth
☐Broken fillings	☐Mouth breathing	☐Thumb sucking
☐Clicking/popping TMJ	☐Orthodontic treatment	☐Trauma to mouth or teeth
☐Complications from extractions	☐Pacifier use	☐Unfavorable dental experience

Please indicate the number of cavities that the child has had in the past three years: ____None ____1-2 _____3+

The following factors increase the risk for future cavities. Please check any that apply to your child:

__ Active orthodontic treatment *	__Chemo/radiation therapy*	*High Risk for Cavities
__Cariogenic diet (high sugar or acidic food/beverage)*		
__Xerostomia (dry mouth)*	__Sleeping with bottle (other than water)*	
__Poor oral hygiene	__Multiple medications	
__Family history of poor oral health	__ Many large, multi surface fillings	
__Inconsistent professional dental care	__Eating disorders	
__Misalignment of teeth	__ Developmental or acquired enamel defects	

I consent to routine dental care for my child including: diagnostic procedures, comprehensive and routine exams, dental scalings (cleanings) and polishing of teeth, radiographs, intraoral and extraoral photographs, local anesthetic, and restorative procedures, when indicated by the clinicians at Drs. Bagley, Goodwin, & Hrinda, PC. Treatment needed above and beyond the routine (such as surgery, root canal therapy, etc.) will be explained and planned separately, with consent for that treatment plan being given at that time.

Guardian's Signature_____ Date_____