CHILD REGISTRATION FORM

Child's Name_____ Male_____ Female_____ Birth date_____
Mo. Day Year

Address_____ City_____ Zip_____ Home Phone_____

Person responsible for payment on account: Father_____ Mother_____ Other_____

Child's Hobbies? Interests _____

Whom May We Thank For Referring You? _____

Last Dental Visit? _____

PARENT INFORMATION

Father's Name_____ Birth date _____

Address_____ City_____ Zip_____ Home Phone _____

Employed By_____ Occupation _____ Cell Phone _____

Business Address_____ Business Phone _____

Insurance Co._____ Social Security Number _____

Mother's Name_____ Birth date _____

Address_____ City_____ Zip_____ Home Phone _____

Employed By_____ Occupation _____ Cell Phone _____

Business Address_____ Business Phone _____

Insurance Co._____ Social Security Number _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING

	No	Yes		No	Yes		No	Yes
Poor Health	❑	❑	H.I.V.+/A.I.D.S.	❑	❑	Epilepsy/Seizures/Fainting	❑	❑
Heart Problems	❑	❑	Venereal Disease	❑	❑	Cancer/Chemo/Radiation	❑	❑
Heart Murmur	❑	❑	Hemophilia/Abnormal Bleeding	❑	❑	Drug/Alcohol Abuse	❑	❑
Rheumatic Fever	❑	❑	Thyroid Problems	❑	❑	ALLERGY TO:		
Mitral Valve Prolapse	❑	❑	Liver Problems	❑	❑	Latex	❑	❑
Heart Valve Replacement	❑	❑	Lung Problems	❑	❑	Penicillin	❑	❑
Artificial Joint	❑	❑	Psychiatric Problems	❑	❑	Novocaine	❑	❑
High/Low Blood Pressure	❑	❑	Sinus Problems	❑	❑	Codeine/Aspirin	❑	❑
Hepatitis A/B	❑	❑	Asthma/Bronchitis	❑	❑	Barbiturates	❑	❑
Herpes	❑	❑	Diabetes	❑	❑	Sulfa	❑	❑
Anemia	❑	❑	Bulimia/Anorexia	❑	❑	Other Drugs	❑	❑
			Tuberculosis	❑	❑			

Date Of Last Medical Exam / Reason_____ Medical Dr. Name_____

	No	Yes	If yes, please list
Have you ever been put to sleep for an operation?	❑	❑	_____
Are you pregnant?	❑	❑	_____
Are you under the care of a physician?	❑	❑	_____
Have you ever responded unfavorably to medical or dental care?	❑	❑	_____
Have you been hospitalized within the last 5 years?	❑	❑	_____
Have you ever had a blood transfusion?	❑	❑	_____
Any other health condition we should know about?	❑	❑	_____
Are you now taking medicine of any kind?	❑	❑	_____

If so, please list_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____