REGISTRATION AND HISTORY

Central CT Pediatric Dentistry and Orthodontics

Date: ______________________

Patient Name: __________________________________ M/F Nick Name: ________________________ Age: _______ DOB: __________

Residence Address: ____City ________________________State ________Zip ____________

Brother's/Sister's
Names and Ages: _______________________________________ Favorite Hobby/Toy______________________Present Weight __________

School ____Grade ______________________ Pet _____________________

ACCOUNT INFORMATION

FATHER'S NAME: ____

ADDRESS: ____

PHONE (HOME): _________________(WORK): ________________

CELL: ________________________

EMAIL ADDRESS: ____

EMPLOYER/DIVISION: ____________________________________

ADDRESS: ____

DENTAL INS. CO. _______________________________________

INS. ADDRESS: ____

POLICY # ____

SOCIAL SECURITY # _____________________________________

DATE OF BIRTH: ____

MOTHER'S NAME: ____

ADDRESS: ____

PHONE (HOME): _________________(WORK): ________________

CELL: _________________________

EMAIL ADDRESS: ____

EMPLOYER/DIVISION: ____________________________________

ADDRESS: ____

DENTAL INS. CO. _______________________________________

INS. ADDRESS: ____

POLICY # ____

SOCIAL SECURITY # _____________________________________

DATE OF BIRTH: ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

DENTAL HISTORY

Reason for visit: ☐ Routine Care ☐ Orthodontic Care

Specific Concerns: ____

Is this the first dental visit? (Yes or No) _________________________

If No, previous dentist's name/address: ___________________________

____

Date of last visit: ____

	YES	NO
Has child complained about dental problems?	☐	☐
Any unhappy dental experiences?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any mouth habits - thumbsucking, nail biting, sippy cup, mouth breathing, nursing bottle habits, pacifier, etc	☐	☐
Does child snore?	☐	☐
Any unusual speech habits?	☐	☐
Any lost teeth?	☐	☐
Do you desire complete dental service for the child?	☐	☐

	YES	NO
Have missing teeth been replaced?	☐	☐
Orthodontic appliances, worn now or ever?	☐	☐
Parents ever wear braces?	☐	☐
Does your child brush daily?	☐	☐
Does your child use toothpaste?	☐	☐
Do you assist child with toothbrushing?	☐	☐
How often? ___________________________		
Is dental floss used?	☐	☐
How often? ___________________________		
Family history of gum disease?	☐	☐
Parents' history of dental decay?	☐	☐
Is fluoride taken in any form?	☐	☐

Child's attitude to dentistry_____________________________

Parents' attitude toward dentistry __________________________

PLEASE COMPLETE REVERSE SIDE ALSO

MEDICAL AND HEALTH HISTORY

Child's Physician: ___________________________________Address _________________________________Telephone _____________________

Last date of physical exam ____________________ Results ____

	YES	NO
1. Is child under the care of a physician now?	☐	☐
Name of Dr. ______________________________		
Reason: __________________________________		
2. Is child receiving any medication or drugs? ____ ____	☐	☐
3. Is there excessive bleeding when cut? _________ ____	☐	☐
4. Has child ever been hospitalized?_____________ ____	☐	☐
5. Has child ever had surgery? Age: _______	☐	☐
Reason: ____________________________________		
6. Is your child or any family member allergic to latex? ____	☐	☐

	YES	NO
7. Any other allergies?	☐	☐
a. Drugs, Penicillin, etc_________________________		
b. Food, peanuts, pollen, dust, other:______________		
8. Does child have good physical coordination?	☐	☐
9. Are there any physical problems?____________ ____	☐	☐
10. Any learning difficulties? _________________ ____	☐	☐
11. Does child get upset easily? ________________	☐	☐
12. Any problems at birth/before birth? __________ ____	☐	☐
13. Are immunizations current?	☐	☐

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia	___ Convulsions	___ HIV	___ Mononucleosis	___ Mumps
___ Asthma	___ Diabetes	___ Hearing	___ Kidney	___ Rheumatic Fever
___ Bladder	___ Epilepsy	___ Heart	___ Liver	___ Thyroid
___ Cerebral Palsy	___ Fainting	___ Heart Murmur	___ Malignancies	___ Transfusions
___ Chicken Pox	___ Hernia	___ Hepatitis	___ Mastoid	___ Tuberculosis
___ Chronic Sinus	___ Frequent Infections	___ High Fever	___ Measles	___ Other

Please describe any current or past medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of:

____

____

May we request release of your child's medical records for our reference? ☐ **YES** ☐ **NO**

SUMMARY: (for doctor's use)

PERMIT FOR TREATMENT UPON A MINOR

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status.

I, being the parent or guardian of the above minor patient, have the authorization and do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics, which may be deemed advisable by the Doctor.

I will be informed of all services and their charges by this office before any of the services are rendered.

Furthermore, I understand as the parent or guardian I will be responsible for all financial obligations incurred on this child for dental treatment whether or not I accompany this child to the office visit. There will be a 1-1/2% monthly finance charge for all accounts 60 days or more past due. Should this account be referred to a collection agency for non-payment all collection and attorneys' fees will be the responsibility of the debtor.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: ____

(Signature of Parent/Guardian and Relationship to Child)

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