Phone: 321-725-9946
Fax: 321-951-7389
6050 Babcock St. SE
Palm Bay, FL 32909

CHILD REGISTRATION AND HISTORY

In order for us to better serve you, please complete this form.
The information is, of course, confidential and will be protected. Thank you.

1. PATIENT'S HISTORY

Date_____

CHILD'S NAME *(First-Middle-Last)*_____ Nickname_____

Date of Birth_____ Age_____ Sex_____ Race_____ School_____ Grade_____

Child's Home Address_____ Apt._____ City_____ Zip_____

Names and Ages of Brothers/Sisters_____

Child's Physician_____ Office Phone_____

2. GENERAL INFORMATION

Would you like to receive text/email reminders? ☐ Yes ☐ No

FATHER / LEGAL GUARDIAN'S FULL NAME

_____

D.O.B _____ Drivers Lic #_____

Social Security #_____

Employer_____

Home Phone #_____

Cell Phone #_____

Work Phone #_____

Email_____

MOTHER / LEGAL GUARDIAN'S FULL NAME

_____

D.O.B _____ Drivers Lic #_____

Social Security #_____

Employer_____

Home Phone #_____

Cell Phone #_____

Work Phone #_____

Email_____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single

Child's Medicaid ID Number_____

Is your child covered under any other dental insurance? ☐ Yes ☐ No Insurance company_____

Reason for this visit_____

3. MEDICAL HISTORY

DOES YOUR CHILD HAVE OR EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

	YES	NO		YES	NO		YES	NO
Measles	☐	☐	Speech Problems	☐	☐	Epilepsy	☐	☐
Mumps	☐	☐	Heart Trouble	☐	☐	Convulsions/Seizures	☐	☐
Chicken Pox	☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐
Whooping Cough	☐	☐	Excessive Fever	☐	☐	Anemia	☐	☐
ADD/ADHD	☐	☐	Blood Pressure (H-L)	☐	☐	Bipolar Disorder	☐	☐
Hay Fever	☐	☐	Liver Disease/Hepatitis	☐	☐	Asthma	☐	☐
Hearing Deficiency	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Visual Deficiency	☐	☐	Lung Disease	☐	☐	Autism/Asperger's Syndrome	☐	☐
Premature	☐	☐	Frequent Nose Bleeds	☐	☐	Fainting Spells	☐	☐
Birth Defects	☐	☐	AIDS/HIV	☐	☐	Blood Transfusions	☐	☐

What is your child's present weight?_____ Height?_____

Is your child under medical care at present?_____

Date of last physical examination_____

Condition of child's general health_____

Is your child taking any medications? If so, What?_____

Is your child mentally or physically handicapped?_____

Do you consider your child to be high strung or generally nervous? _____

Has your child ever been hospitalized? ☐ Yes ☐ No - If Yes, For What? _____

Has your child had any history of sore throats, tonsillitis, or earache? _____

Does your child suffer from motion sickness? _____

Is your child allergic to any foods? ☐ Yes ☐ No - If Yes, List _____

Is your child allergic to any medications? ☐ Yes ☐ No - If Yes, List _____

Is your child allergic to penicillin? _____

Is your child sensitive to latex products? _____

Did your child ever receive antibiotics? ☐ Yes ☐ No - If Yes, What? _____

When? (age) _____ How Long? _____

Has your child been exposed to unpleasant dental or medical experiences? _____

Explain _____

Is your child having any difficulty in school? _____

Are there any psychological or emotional problems you would like to bring to our attention? _____

_____

Is there any other pertinent medical information of which I should be aware in order to best treat your child? _____

_____

4. DENTAL HISTORY

Date of last dental care _____ Where? _____

How do you think your child will act at the dental office? _____

Has your child experienced a traumatic accident involving their teeth or gums? Please Describe circumstances and date of Accident._____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any dental service can be started and accomplished.

PERMISSION FOR DENTAL TREATMENT UPON A MINOR

Patient's Name _____ Date of Birth _____

I, being the parent of guardian of the above minor patient, do hereby authorize and request the performance of dental exams and treatment for this patient; I further authorize any dental or behavioral management techniques deemed necessary by your child's treating doctor of staff to complete a course of dental treatment.

Additionally, I understand that **office policy** dictates that parent/guardians remain in the reception area, and will not be allowed to accompany their child(ren) into the treatment area. This allows us to establish a direct relationship with your child, and is an accepted principle in the practice of children's dentistry.

I also authorize the administration of local anesthetics or analgesia (nitrous oxide/laughing gas) which may be deemed advisable by the doctor.

I AUTHORIZE the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance claim submissions.

PLEASE NOTE:
Your appointment is a reservation of space, doctor time, and the time of a number of dental assistants. **A $35.00 charge may be made for appointments broken or cancelled without adequate notice.** In addition, our office policy requires at least **48 hours notice** if a scheduled appointment cannot be kept. Should it be necessary to transfer your child out of our office at some future time, **there may be a charge of $24.00 for a copy of the most recent bitewing and panoramic x-rays.**

Print Name _____ Signature X _____

Relationship _____ Date _____