West Mobile CHILDREN'S Dentistry

Patient Registration and Health History

Patient's Name:_____ Preferred Name:_____

Date of Birth: _____ Gender:_____

Child's Home Address:_____

City:_____ State:_____ Zip Code:_____

School: _____ Grade:_____

Please list some of your child's interests:

_____

How did you hear about our office? _____

Family Information

Who has legal custody of the child? _____

Parent's Marital Status: Single ___Married ___Separated___Divorced___Widowed___

With whom does the child live?_____

List brothers/sisters with ages:_____

Signature of Parent/Guardian:_____ Date:_____

Guardian's Information

1) Name:_____ Relationship to patient:_____
Birthdate: _____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Employer:_____

2) Name:_____ Relationship to patient:_____
Birthdate:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Employer:_____

Responsible Party and Primary Dental Insurance

Person Responsible for Account and relationship to patient:_____

Insurance Company Name:_____

Policy ID:_____ Policy Group #:_____

Policy Holder's Birthdate:_____ Policy Holder's Social Security Number: _____

Policy Owner's Employer:_____

Secondary Dental insurance:_____

Signature:_____ Date:_____

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Health History

Is this your child's first dental visit? Yes__ No__ Last Visit Date:_____

At which office was your child previously seen?_____

How do you think your child will do at today's dental visit?_____

Has your child been to an orthodontist?_____

Do you have any concerns about your child's teeth?_____

Has your child had any injuries to the face, mouth, teeth or chin?_____

Has your child had any pain or tenderness in his/her jaw joints?_____

Does your child brush his or her teeth daily? Yes___ No___

Does your child floss his or her teeth daily? Yes___ No___

Is your home water supply city water or well water?_____

Does your child:

Suck a thumb or finger/fingers? Yes___ No___

Suck a pacifier? Yes___ No___

Use a bottle or nurse? Yes___ No ___

Who is your child's pediatrician?_____ Phone Number:_____

When was your child last seen by his/her pediatrician?_____

Signature:_____ Date:_____

Health History Continued

Please List all medications/ things your child is allergic to or write None:_____

Is your child taking any medications? If yes, Please list them

_____

Is your child allergic to: Latex…… Yes___ No___ Metals/Nickel….. Yes___ No___

Plastics….. Yes___ No___ Penicillin….. Yes___ No___

If Yes, What type of reaction?_____

Has your child ever had any of the following medical problems?

Y	**N**	Abnormal Bleeding	**Y**	**N**	Developmental Delay
Y	**N**	ADD/ADHD	**Y**	**N**	Diabetes
Y	**N**	Anxiety	**Y**	**N**	Down Syndrome
Y	**N**	Asthma	**Y**	**N**	Endocrine disorder
Y	**N**	Anemia	**Y**	**N**	Hearing Impairment
Y	**N**	Autism/Autism Spectrum	**Y**	**N**	Heart Murmur
Y	**N**	Disorder/Asperger's	**Y**	**N**	High Blood Pressure
Y	**N**	Behavioral disorders	**Y**	**N**	HIV/AIDS
Y	**N**	Bone/joint problems	**Y**	**N**	Hemophilia
Y	**N**	Cleft lip/palate	**Y**	**N**	Hepatitis
Y	**N**	Congenital Heart Defect	**Y**	**N**	Kidney Disorder
Y	**N**	Cancer	**Y**	**N**	Liver Disorder
Y	**N**	Depression	**Y**	**N**	Lupus
Y	**N**	Physical Handicap or Impairment	**Y**	**N**	Rheumatic/Scarlet Fever
Y	**N**	Seasonal Allergies	**Y**	**N**	Seizures/ Epilepsy
Y	**N**	Sensory disorder	**Y**	**N**	Sensory disorder
Y	**N**	Sickle Cell Disease/ Trait	**Y**	**N**	Tuberculosis
Y	**N**	Speech Impairment/Disability	**Y**	**N**	Vision Impairment
Y	**N**	Stomach/GI Disorders/ Acid Reflux			

Any Hospital Stays….. Yes___ No___ Reason: _____

Signature:_____ Date:_____