Welcome

South Hill Children's Dentistry
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Registration Form

For your convenience… Print this form, complete all information, and bring it with you on your first visit to our office. *The parent or guardian who accompanies the child is responsible for payment at the time of service.*

1. **Tell us about your child:**

Child's Name_____
Last First MI

Preferred Name_____ □ Male □ Female

Siblings that we treat_____

Child's Birthdate___/___/___Age_____

Child's home phone_____

Child's mailing address_____
street

_____
city state zip

2. **Who may we thank for referring you to our office?**

_____

3. **Mother's Information:**

Name_____
Last First MI

o Married o Single o Divorced Birthdate___/___/___

Employer_____

Home#_____Work#_____

Cell #_____SSN_____

Address (if different)_____

_____

Email address_____

4. **Father's Information:**

Name_____
Last First MI

o Married o Single o Divorced Birthdate___/___/___

Employer_____

Home#_____Work#_____

Cell #_____SSN_____

Address (if different)_____

_____

Email address_____

5. **Consent for treatment:**

Will anyone **other than mom or dad** bring your child into future appointments (**must be 18 years old or older**)?

Name_____

Relationship to child _____

6. **Consent for email or texting communication:**

I understand by giving the dental practice my email and/or cell phone number that I am giving my express consent to use these as a source of communication for emails and texting.

Cell #_____

Email address_____

7. **Primary Dental Insurance:**

Insurance Co. name_____

Insurance Co. address_____

_____

Group # (Plan, Local or Policy #)_____

Policy Owner's Name_____

Relationship to child _____

Policy Owner's birthdate___/___/___

SSN _____

Policy Owner's Employer_____

8. **Secondary Dental Insurance:**

Insurance Co. name_____

Insurance Co. address_____

_____

Group # (Plan, Local or Policy #)_____

Policy Owner's Name_____

Relationship to child _____

Policy Owner's birthdate___/___/___

SSN _____

Policy Owner's Employer_____

Medical History

Is your child currently under the care of a physician? □ Yes □ No

If yes please explain_____

_____

Child's Physician:_____

Physician phone#:_____ Date of last visit:_____

Address:_____
Street City State Zip

Please describe your child's current physical health: □ Good □ Fair □ Poor

Are immunizations current? □ Yes □ No

Please list all medications your child is currently taking:_____

Is your child allergic to any foods, environmental pollutants, animals or medicines? If so please list specifics:_____

_____

_____

Has your child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Surgeries
Y N Asthma
Y N Autism
Y N Cancer
Y N Cerebral Palsy
Y N Cleft Palate / Lip
Y N Diabetes
Y N Epilepsy / Seizures
Y N Handicaps / Disabilities
Y N Hearing / Speech
Y N Heart Disease
Y N Heart Murmur
Y N Hemophilia Type_____
Y N Hepatitis Type ____
Y N High / Low Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Rheumatic Fever
Y N Sickle Cell Anemia
Y N Tuberculosis (TB)

Please discuss the above and any other medical problems your child has / had:_____

_____

_____

Do you consider your child to be : □ Progressing normally in the learning process □ Slow in the learning process

Dental History

What is the ***primary*** reason for today's visit?_____

Is your child currently having problems with any of the following?

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma
□ Gum Infection □ Color of Teeth □ Tooth Alignment □ Other _____

Has your child experienced problems with previous dental work? □ Yes □ No Explain:_____

Is your child's home water supply fluoridated? □ Yes □ No

Does your child brush their teeth daily with fluoride toothpaste? □ Yes □ No

Do you give your child any other form of fluoride? □ Yes □ No If yes, what?_____

Does your child floss their teeth daily? □ Yes □ No

Was your child bottle or breast-fed? _____ At what age was it completely stopped?_____

Does your child suck a finger, thumb or pacifier or exhibit any other habits? _____

Previous/Present (circle) Dentist:_____ Date of last visit:_____

Why did you leave your last dentist?_____

What did you like most about any dentist you have seen?_____ Least? _____

Signature_____ **Date** _____

Relationship to Child _____