Charles Keith Dentistry

CHILD'S REGISTRATION AND HISTORY Today's date:_____

Child's Last Name: _____ First Name: _____ Middle Initial:_____ Nickname: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security#:_____ Date of Birth: _____ Age: _____

Home Phone: _____ School:_____ Grade: _____

Father's Name: _____ Mother's Name: _____

Father's Employer: _____ Work Phone:_____ Cell Phone: _____

Mother's Employer: _____ Work Phone:_____ Cell Phone: _____

Person Financially Responsible (if other than parent) _____ Relationship to child: _____

Child/Minor's Physician:_____ Phone Number:_____

In case of emergency, please notify: _____ Phone: _____

Does your child have Dental Insurance? ☐ Yes ☐ No

Insured Employee's Name: _____ Social Security #: _____

Insured Employer: _____ Insured's Date of Birth: _____

Insurance Co. Name: _____ Phone#: _____ Group# (Plan, Local or Policy#): _____

Date of last visit to dentist? _____ Is your child currently in pain? _____

Does your child brush teeth daily? _____ Does your child floss daily? _____ Do their gums bleed? _____

Are teeth sensitive to heat, cold or anything else? _____ Are there any loose or mobile teeth? _____

Has the child/minor had any history of or difficulty with any of the following?

○ Anemia	○ Convulsions	○ Kidney	○ Mumps
○ Asthma	○ Diabetes	○ Liver	○ Rheumatic Fever
○ Bladder	○ Epilepsy	○ Malignancies	○ Thyroid
○ Cerebral Palsy	○ Fainting	○ Mastoid	○ Tuberculosis
○ Chicken Pox	○ Hearing	○ Measles	○ Other
○ Chronic Sinus	○ Heart	○ Mononucleosis	○ Venereal Disease

Please list any serious medical condition(s) that your child has experienced? _____

Is he/she taking any prescription I over the counter drugs? ☐ Yes ☐ No If yes, please list each one:_____

_____

Is your child allergic to any of the following?

○ Aspirin	○ Dental Anesthetics	○ Latex	○ Sulfa Drugs
○ Barbiturates	○ Erythromycin	○ Penicillin	○ Tetracycline
○ Codeine	○ Jewelry / Metals	○ Sedatives	○ Other

Please list anything additional that causes allergic reactions: _____

_____

Authorization

I affirm that the information I have given Is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the denial staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature: _____ Date: _____

SUBMIT