

## Child's Registration and History

### I. Child's History:

Name	(last)	(first)	(middle)	(preferred name)
Child's Home Address		Home Phone		With Whom Does Child Live
Age	Date of Birth	Gender (Male or Female)		
Attends what school	Grade	List brothers and sisters and ages		

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### II. Dental History

Is this your child's first dental visit? _____ Yes/ No	Any lost teeth ? _____ Yes/No
Name of previous dentist _____	Explain _____
Date of last visit to a dentist _____	Have missing teeth been replaced? _____ Yes/No
For what service _____	Orthodontic appliances worn now or previous? _____ Yes/No
Reason for referral _____	Explain _____
Any mouth habits – thumbsucking, nail biting, mouthbreathing, snoring, nursing or bottle habits, pacifier, etc. (circle/explain)? _____ Yes/No	How often are your child's teeth brushed? _____
Has child complained about dental problems? _____ Yes/No	Do you assist your child with tooth brushing (how often)? _____ Yes/No
Explain _____	Is dental floss used (how often)? _____ Yes/No
Any unhappy dental experiences ? _____ Yes/ No	Is fluoride taken in any form? _____ Yes/No
Explain _____	Is your drinking water fluoridated? _____ Yes/No
Any injuries to mouth, teeth, or head ? _____ Yes/No	Child's attitude toward dentistry (explain) _____
Explain _____	Do you desire complete dental service for your child? _____ Yes/No
Any unusual speech habits ? _____ Yes/No	Do you want your child to have straight teeth? _____ Yes/No
Explain _____	

### III. Medical History

Physician's Name _____	Has child ever been hospitalized? _____ Yes/No
Physician's Telephone # _____	
Has your child had a physical exam in last year? _____ Yes/No	Has child ever had surgery? _____ Yes/No
Is your child under care of physician now _____ Yes/No	Allergy to penicillin or other drugs (list) _____ Yes/No
General Health (please check) Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>	Other allergies: food – pollen – animals – dust – latex – other (list) _____ Yes/No
Is child taking any medication now _____ Yes/No	Does child have good physical coordination (explain)? _____ Yes/No
Name of Medication _____	Are there behavioral or developmental problems (explain)? _____ Yes/No
Prescribed by whom? _____	How is your child doing in school? _____
For what purpose? _____	
Is child taking any Herbal or Complimentary medicines? Yes/No	
Name of Medication & purpose? _____	
_____	

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

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Chronic Sinus        | <input type="checkbox"/> Fever            | <input type="checkbox"/> Liver/GI           | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Craniofacial         | <input type="checkbox"/> Hearing          | <input type="checkbox"/> Malignancies       | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma (Pulmonary) | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Heart            | <input type="checkbox"/> Measles/Mumps      | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Bladder            | <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Ears                 | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Orthopedic         | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Kidney           |   |  |

I understand that the information I provide on this form is essential to determine my child's dental treatment. I understand that if any change occurs in my child's health I am to report it to the dental office as soon as possible.

\_\_\_\_\_  
Please Initial & Date

## GENERAL INFORMATION

### Guardian #1 information: Relationship to patient \_\_\_\_\_

Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Work Phone/Pager # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  
Cell Phone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ E-mail address \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Place of Employment \_\_\_\_\_  
Employment Address \_\_\_\_\_  
Dental Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Mailing Address \_\_\_\_\_  
Insurance Co. Telephone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Policyholder name \_\_\_\_\_

### Guardian #2 information: Relationship to patient \_\_\_\_\_

Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Work Phone/Pager # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  
Cell Phone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ E-mail address \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Place of Employment \_\_\_\_\_  
Employment Address \_\_\_\_\_  
Dental Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Mailing Address \_\_\_\_\_  
Insurance Co. Telephone # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Policyholder name \_\_\_\_\_

### Person Financially Responsible \_\_\_\_\_

Relationship to Child \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Work # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

### Person to contact in case of emergency if you cannot be reached:

Name \_\_\_\_\_ Home # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Work # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  
Name \_\_\_\_\_ Home # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Work # (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

### CONSENT:

Your child is a minor; therefore, it is necessary that a signed permission be obtained from a parent or guardian before any dental services can be started. I grant Indianapolis Pediatric Dentistry permission to provide my child with dental care and I will be responsible for the total cost of the dental care.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL POLICIES

Please read the following carefully before signing:

1. Payment is due in full at the time services are rendered. As a courtesy, we will be happy to file your insurance for you.
2. We accept personal checks, MasterCard, Visa, and cash.
3. A monthly service fee plus interest will be charged on all accounts with an outstanding balance.
4. Cancellation policy: Our office needs 48 hours notice of cancellation. For any appointment that is not cancelled, a fee of \$50.00 per 30 minutes scheduled can be charged to your account. As we usually have patients on a waiting list, we appreciate your call if you will need to reschedule your appointment.
5. The responsible party is the parent that brings the child in for the dental visit, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

The undersigned agrees to be financially responsible for any dental charges incurred, which may include interest fees, the cost of collection agencies, court cost and any attorney fees for accounts that are not paid when due for: \_\_\_\_\_.

Child's Name

Signed \_\_\_\_\_  
(Parent or Guardian)

Date \_\_\_\_\_

Indianapolis  
Pediatric  
Dentistry



A \$30.00 fee will be charged to your account for any check that is returned for non-sufficient funds.