KIDS FIRST
PEDIATRIC DENTISTRY & ORTHODONTICS

NEW PATIENT REGISTRATION

Date_____

Patient's Full Name _____ M/F _____ Nickname_____

Date of Birth _____ Age_____

Address _____ City_____ State_____ Zip_____

PARENT/GUARDIAN ACCOUNT INFORMATION

Name:_____ Name:_____

Address: _____ Address: _____

Phone (Home): _____ Phone (Home): _____

Phone (Cell): _____ Phone (Cell): _____

Phone (Work): _____ Phone (Work): _____

E-Mail: _____ E-Mail: _____

Employer/Division: _____ Employer/Division: _____

Address: _____ Address: _____

Primary Dental Insurance Co.: _____ Secondary Dental Insurance Co.: _____

Address: _____ Address: _____

Membership/Policy#: _____ Membership/Policy#: _____

Social Security #: _____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

Relationship: _____ Relationship: _____

Person Financially Responsible: _____

Please Tell Us How You Heard Of Our Practice _____
(We would like to thank them)

DENTAL HISTORY

Specific Concerns: _____

Is this your child's first dental visit? (Yes or No) _____ Were X-rays taken? Yes □ No □ Date of last x-ray_____

If No, previous dentist's name: _____ Date of last visit: _____

	Yes	**No**
Do you have well or city water? _____		
Any unhappy dental experiences? _____	□	□
Any oral Habits- thumb sucking, nail biting, pacifier, etc? _____	□	□

Child's attitude toward dentistry: _____

Parent's attitude toward dentistry: _____

MEDICAL AND HEALTH HISTORY

Name: _____ Date: _____ Dr. Signature: _____

Child's Physician_____ City_____ Tel. _____

Date of last physical examination_____ Results_____

	YES	NO
1. Is your child under the care of a physician (other than routine care) now? Name of Dr. _____	□	□
2. Does your child take any medications or supplements? _____	□	□
3. Has your child ever been hospitalized? _____	□	□
4. Has your child ever had surgery? Reason:_____	□	□
5. Is there anything artificial placed in your child's body, such as pins, shunts, rods, etc._____	□	□
6. Does your child have any allergies (i.e, penicillin, latex, nuts, etc. _____	□	□
7. Are there any physical problems? _____	□	□
8. Are there learning difficulties? _____	□	□
9.Has your child been diagnosed with a spectrum disorder _____	□	□
10. Were there problems at or before birth? _____	□	□
11. Does your child have bleeding disorders _____	□	□

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

□ Anemia	□ Diabetes	□ Heart/Heart Murmur	□ Malignancies
□ Asthma	□ Epilepsy	□ Hepatitis	□ Rheumatic Fever
□ Cerebral Palsy	□ Frequent Infections	□ HIV	□ Thyroid
□ Chronic Sinus	□ Headaches	□ Kidney	□ Tuberculosis
□ Convulsions	□ Hearing	□ Liver	□ Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of:

_____

_____

	YES	NO
May we request release of your child's medical records for our reference? _____	□	□

PERMIT FOR TREATMENT UPON A MINOR

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment.

I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor.

Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligation incurred on this child for dental treatment.

I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: _____

(signature and relationship to patient)