Laurelwood Dental

Child Registration

About Your Child

Today's Date: _____ E-mail Address: _____

Child's Name: _____ They prefer to be called: _____ male ☐ female ☐
Last First MI

Child's Birthdate: ____/____/____ Age: _____

Home Address: _____
Street City State Zip

Child lives with: ☐ Mother ☐ Father ☐ Other: _____

Whom may we thank for referring you? _____ OR _____
Friend / Relative / Doctor Internet Site

Responsible Party Information

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext.: _____

Home Phone #: _____ Cell #: _____ When are the best times to reach you?: _____

Mother / Step Mother / Guardian Information

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext.: _____

Home Phone #: _____ Cell #: _____ When are the best times to reach you?: _____

Father / Step Father / Guardian Information

His / Her Name: _____ Birthdate: ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: _____ Ext.: _____

Home Phone #: _____ Cell #: _____ When are the best times to reach you?: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone #: _____ Group / Plan #: _____

ID #: _____ Insured's Employer: _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's SS #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Secondary Insurance Company: _____ Phone #: _____ Group / Plan #: _____

ID #: _____ Insured's Employer: _____

Insurance Co. Address: _____
Street / PO Box City State Zip

Insured's Name: _____ Insured's SS #: _____ Insured's Birthdate: ____/____/____ Relation: _____

Laurelwood Dental

Child Health Questionnaire

Today's Date: _____

Patient name: _____

Date of birth: _____

The purpose of the following questions is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record.

Name of physician: _____ Physician phone: _____

More Info About Your Child

Why did you bring the child to the dentist today? _____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his/her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____ Phone #: _____ Date of last visit: _____

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

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has the child ever taken Phen-Fen (aka Redux or Pondimin)? ☐ Yes ☐ No If so, when? _____

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items below, list all drugs / materials that the child is allergic to: _____

_____

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

- ☐ Abnormal Bleeding
- ☐ ADD / ADHD
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ Artificial Bones / Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Convulsions / Epilepsy
- ☐ Diabetes
- ☐ Handicaps / Disabilities
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV+ / AIDS
- ☐ Kidney / Liver Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Sickle Cell Disease / Traits
- ☐ Tuberculosis (TB)

Does the child have any of the following habits?

- ☐ Lip Sucking / Biting
- ☐ Nail Biting
- ☐ Nursing Bottle Habits

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.