FLORIDA FAMILY DENTAL
ORTHODONTIC AND IMPLANT CENTER

CHILD REGISTRATION & MEDICAL HISTORY

Your childs complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 ABOUT CHILD

Today's Date:_____

Name:_____
LAST FIRST MI

Nickname:_____ ❑ Male ❑ Female

Birthdate:__/__/__ Age:_____ SS #:_____

Home Address:_____
APT / CONDO #

_____
CITY STATE ZIP

Home #: (___)_____Cell #: (___)_____

Where and when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

2 PARENT INFORMATION

Father's Name:_____

Birthdate:__/__/__ Age:_____ SS #:_____

Employer:_____

Home #: (___)_____Cell #: (___)_____

Work #: (___)_____Ext:_____DL #:_____

Mother's Name:_____

Birthdate:__/__/__ Age:_____ SS #:_____

Employer:_____

Home #: (___)_____Cell #: (___)_____

Work #: (___)_____Ext:_____DL #:_____

Person Responsible for Account:

Work #: (___)_____ Ext: ____ Home #: (___)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer:_____ DL #: _____

ARE YOU ON MEDICAID? ❑ YES ❑ NO

DO YOU HAVE DSHS COUPONS? ❑ YES ❑ NO

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate:__/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, who should be notified, other than a parent?

Name:_____Relation:_____

Address:_____

Work #: (___)_____Home #: (___)_____

4 MEDICAL HISTORY

Does your child have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

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

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY continued

Date of last physical:_____

Child's current physical health is: ❑ Good ❑ Fair ❑ Poor

Is child taking any prescription, over-the-counter, or supplement drugs? ❑ Yes ❑ No

Please list each one:_____

_____

Does your child smoke or use tobacco in any other form? ❑ Yes ❑ No

Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

- ❑ Aids or Other Immunosuppressive Disorders
- ❑ Allergies to Anesthetics
- ❑ Allergies to Medicines or Drugs
- ❑ Asthma
- ❑ Artificial Heart Valves or Joints
- ❑ Bladder Problems
- ❑ Cerebral Palsy
- ❑ Chemical Dependency
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Hearing Problems
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis, Jaundice, or Liver Disease
- ❑ Kidney Problems
- ❑ Mononucleosis
- ❑ Radiation Treatment
- ❑ Rheumatic Fever
- ❑ Thyroid Problems
- ❑ Tuberculosis

Please list any serious medical condition(s) that your child has had:

_____

_____

Is your child allergic to any of the following?

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Jewelry/Metals
- ❑ Latex
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other

Please list any other drugs/materials that child is allergic to:_____

_____

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

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

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

When was child's last dental visit?_____

Experiencing any discomfort now?_____

Do you desire complete dental service for your child?_____

Has your child ever responded adversely to medical or dental treatment?

_____

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work? ❑ Yes ❑ No

Is there anything else we should know about child's dental history?_____

_____

How many times a week does child floss?_____

How many times a day does child brush?_____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that if credit is requested, a credit check may be required and I hereby grant Dr._____ this authorization.

I hereby authorize payment directly to Florida Family Dental for the dental benefits otherwise payable to me.

_____

Signature Date

_____

Relationship to child

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: Date:

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____
2. Date: _____ Comments: _____ Signature: _____
3. Date: _____ Comments: _____ Signature: _____