Pediatric Dental Registration Form

Patient information

Patient name: _____ DOB: _____

Preferred name/Nickname: _____ Patient gender: Male/Female

Parent name: _____

Phone number: (Home)_____ (Cell) _____

Street Address: _____

City: _____ State: _____ Zip: _____

We offer appointment reminders via email. Please offer us your email information if you would like to receive these reminders.

Parent email address: _____

Dental insurance information

Dental insurance company: _____

Subscriber: _____ DOB: _____

Employer: _____

Subscriber/Insurance ID number: _____

Group/Plan number: _____

Insurance phone number: _____

Dental Habits

How often does your child brush his/her teeth? _____

How often does your child floss? _____

We routinely place fluoride treatment on the teeth of children ages 14 and younger to help strengthen the teeth and prevent decay. Would you like us to use fluoride treatments on your child? Please circle: Yes No

Please indicate if your child currently has, or in the past has had, any of the following medical concerns:

○ Abnormal Bleeding/Hemophilia

○ ADD/ADHD

○ Anemia

○ Asthma/Breathing Disorders

○ Autism Spectrum Disorder/Asperger's

○ Cancer/Tumor/Leukemia

○ Cerebral Palsy

○ Cleft Lip/Palate

○ Congenital Birth Defects

○ Cystic Fibrosis

○ Diabetes

○ Eating Disorder

○ Epilepsy/Seizures

○ Heart Murmur/Defect/Surgery

○ Hearing Problems/Deaf

○ Immune Disorder/HIV/AIDS

○ Kidney Problems

○ Jaundice/Hepatitis/ Liver Disease

○ Mental/Cognitive/Social Delay

○ Psychiatric concerns

○ Seasonal allergies

○ Sickle Cell Anemia/Trait

○ Speech Disorder

○ Stomach/GI Problems

○ Tuberculosis (TB)

○ Vision Problems/Blindness

Please indicate if your child has any of the following allergies:

○ Amoxicillin/Penicillin

○ Aspirin

○ Codeine

○ Erythromycin

○ Latex

○ Metals

○ Tetracycline

○ Food (specify):

_____

_____

○ Other (specify):

_____

_____

_____

_____

Please list any medications that your child is taking:

_____

Parent signature _____ Date _____