Name____
last first middle

Child Patient Registration

Child

Child's First Name | Nickname | M.I. | Last Name | Sex | Grade | Age

Child's Home Address | Apt# | City | State | Zip Code

Child's Social Security Number | Birth Date | Home Phone | Email

Responsible Party

First Name | Preferred | M.I. | Last Name | Date of Birth | Relationship to Child

Home Address | Apt# | City | State | Zip Code

Social Security Number | Driver's License Number | Home Phone | Cell Phone | Email

Person responsible for making appointments

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

First Name | Preferred | M.I. | Last Name | Email

Employer | Occupation

Social Security Number | Home Phone | Cell Phone | Email

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

First Name | Preferred | M.I. | Last Name | Email

Employer | Occupation

Social Security Number | Home Phone | Cell Phone | Email

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Partners In Dental Care • 2565 Forest Hill Avenue SE Ste 200 • Grand Rapids, MI 49546-7535
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Primary Insurance

Insured's Name ______ Relationship ______ Date of Birth ______

Home Address ______ Apt# ______ City ______ State ______ Zip Code ______

Social Security Number ______

Employer ______ Position ______ Date of Employment ______

Insurance Company ______ Group Number ______ Employee Number ______

Insurance Company Address ______ City ______ State ______ Zip ______

Deductable ______ Co-Pay ______ Amount already used ______ Maximum annual benefit ______

Additional Insurance

Insured's Name ______ Relationship ______ Date of Birth ______

Home Address ______ Apt# ______ City ______ State ______ Zip Code ______

Social Security Number ______

Employer ______ Position ______ Date of Employment ______

Insurance Company ______ Group Number ______ Employee Number ______

Insurance Company Address ______ City ______ State ______ Zip ______

Deductable ______ Co-Pay ______ Amount already used ______ Maximum annual benefit ______

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer all of the following questions carefully.

	Yes	No
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
Does your child		
Suck thumb/finger	☐	☐
Suck/bite lip	☐	☐
Bite/chew nails	☐	☐
Chew hard objects	☐	☐
Grind teeth	☐	☐
Clench jaws	☐	☐
Mouth breather	☐	☐

Date of Last Dental Visit: ______

Previous Dentist: ______

Address ______.

	Yes	No
Is your child anxious about the dentist?	☐	☐
Has your child ever taken Fen-Phen/Redux?	☐	☐

How often does your child brush? ______

How often does your child floss? ______

Has your child ever had:	Yes	No
Asthma	☐	☐
Handicaps/disabilities	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
HIV/AIDS	☐	☐
Rheumatic fever	☐	☐
Hemophilia	☐	☐
Congenital heart defects	☐	☐
Abnormal Bleeding	☐	☐
Heart murmur	☐	☐
Stomach, liver, or kidney problems	☐	☐
Convulsions/epilepsy	☐	☐
A persistent cough not associated with illness	☐	☐

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Child's Physician ____________________ Phone

Address ____________________

Previous Hospitalizations | **When?**

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Is your child currently taking any medications?...... **Yes** ☐ **No** ☐ **Yes** **No**

If so, please list: ____________________

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications? .... **Yes** ☐ **No** ☐

If so, please describe: ____________________

____

____

Does your child have a history of allergies to any other substances or materials? (latex, environmental?): ____________________

____

Please explain any other medical problems your child has: ____________________

____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is required at each appointment.

☐ Cash ☐ Personal Check Credit: ☐ VISA ☐ Mastercard ☐ I wish to discuss the office's payment policy

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

____

Patient Signature (or Parent/Guardian if minor) Date

Dentist's Review: ____________________

____

____

____

Signature of Dentist Date

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