CHILD REGISTRATION

Date: _____

Name of minor/child: _____
Last name First name Initial

Sex: ◯ M ◯ F Age: ____ Birthdate:_____ Nickname: _____
Hobbies: _____

Home Address: _____
Street City State Zip

Person financially responsible:_____ Home phone _____
Work Phone _____

Father's name : _____ Work Phone : _____
Home Phone:_____
Cell Phone:_____
Father employed by: _____ Present position:_____
How long held:_____

Mother's name: _____ Work Phone:_____
Home Phone:_____
Cell Phone:_____
Mother employed by:_____ Present position:_____
How long held:_____

Is there Dental Insurance that will cover any part of our services? Yes_____ No _____
Name of Company_____ Group Number _____
Name of subscriber_____ Subscriber I.D. #_____
Subscriber Date of Birth _____

INSURANCE: To avoid any misunderstanding regarding dental insurance, The person responsible should know that all the professional services rendered are charged directly to you and that you are personally responsible for payment of fees. Thank you.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgment*

I, _____Have received a copy of the offices Notice of Privacy Practices.

_____ _____
Print name Signature

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

1. Individual refused to sign
2. Communication barriers prohibited obtaining the acknowledgment
3. An emergency situation prevented us from obtaining acknowledgment
4. Other (Please specify) _____

(continued on other side)

Health History

Date of last medical examination: _____

Does child have or has child ever had.....

- ☐ Anemia
- ☐ Diabetes
- ☐ Hepatitis(any form)
- ☐ infections (other)
- ☐ Allergies
- ☐ To penicillin
- ☐ To local anesthetic
- ☐ To latex
- ☐ Abnormal heart condition
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Abnormal bleeding from a cut
- ☐ HIV/ AIDS

Is your child under the care of a physician now: Yes ◯ No ◯
Is any medication being taken now: Yes ◯ No ◯
If so, what _____

Other physical conditions _____

_____

Name of Physician _____

Telephone number _____

Information given by (signature) _____
Parent or Legal Guardian