STRAIT SMILES
FAMILY DENTISTRY

## CHILD REGISTRATION

Name (First)_____ Last_____ MI_____

Birth Date_____ Gender_____ Main Contact Number_____

Street Address_____ City_____

State_____ Zip Code_____ Parent E-mail_____

Mother's Name_____ Birth Date_____

Cell Phone Number_____ Work Phone Number_____

Mother's Address (if not same as above)_____

Father's Name_____ Birth Date_____

Cell Phone Number_____ Work Phone Number_____

Father's Address (if not same as above)_____

Is someone other than a parent responsible for child or/and this account? YES NO

If yes, Name_____ Phone Number_____

Address_____

## DENTAL INSURANCE INFORMATION

***Name of Dental Insurance***_____

Group # _____ Subscriber ID_____

Name of Subscriber_____

Birthdate_____ SSN_____

***Secondary Dental Insurance***_____

Group #_____ Subscriber ID_____

Name of Subscriber_____

Birthdate_____ SSN_____

I hereby authorize payment of dental benefits made directly to Strait Smiles Family Dentistry.

*Signed (Insured Person)*_____ *Date* _____

***(Please complete reverse side)***

# CHILD DENTAL HISTORY

Date of last dental visit: _____ For what service: _____

***(If "Yes" is marked for any of the following questions, please describe on line given)***

| | *Yes* | *No* |
|---|---|---|
| Has child complained about dental problems? _____ | ❑ | ❑ |
| Any unhappy dental experiences? _____ | ❑ | ❑ |
| Any injuries to mouth, teeth, head? _____ | ❑ | ❑ |
| Any mouth habits, please circle: thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier | ❑ | ❑ |
| Any unusual speech habits? _____ | ❑ | ❑ |
| Any lost teeth? _____ | ❑ | ❑ |
| Have missing teeth been replaced? _____ | ❑ | ❑ |
| Orthodontic appliances worn now or in the past? _____ | ❑ | ❑ |
| Does child brush teeth daily? If yes, how many times a day? _____ | ❑ | ❑ |
| Do you assist child with tooth brushing? If yes, how often? _____ | ❑ | ❑ |
| Is dental floss used? If yes, how often? _____ | ❑ | ❑ |
| Is fluoride taken in any form? If yes, in what form? _____ | ❑ | ❑ |
| Has child ever used nitrous (laughing gas)? | ❑ | ❑ |
| Child's attitude toward dentistry _____ | | |

# CHILD HEALTH HISTORY

Child's physician name/address/phone: _____

Date of last physical exam: _____ Results: _____

| | *Yes* | *No* |
|---|---|---|
| Is child under care of physician now? _____ | ❑ | ❑ |
| Is child receiving any medication or drugs? _____ | ❑ | ❑ |
| Does your child have any allergies? _____ | ❑ | ❑ |
| Does your child have good physical coordination? | ❑ | ❑ |
| Is there excessive bleeding when cut? _____ | ❑ | ❑ |
| Has child ever been hospitalized? _____ | ❑ | ❑ |
| Has child ever had surgery? _____ | ❑ | ❑ |
| Are there any emotional problems? _____ | ❑ | ❑ |

**Has the child had any history of or difficulty with any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| ❑ AIDS | ❑ Chicken Pox | ❑ Fainting | ❑ Kidney | ❑ Mononucleosis | ❑Venereal Disease |
| ❑ Anemia | ❑Chronic Sinus | ❑Hearing | ❑ Liver | ❑ Mumps | ❑ Multiple Sclerosis |
| ❑ Asthma | ❑ Convulsions | ❑ Heart Murmur | ❑ Malignancies | ❑Rheumatic Fever | ❑ Other, please explain |
| ❑ Bladder | ❑ Diabetes | ❑ Heart (other) | ❑ Mastoid | ❑ Thyroid | _____ |
| ❑Cerebral Palsy | ❑ Epilepsy | ❑ HIV Infection | ❑ Measles | ❑ Tuberculosis | _____ |

**Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed:**

_____

_____

***To the best of my knowledge, the above information is complete and correct. I will not hold my dentist or any other 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 a 1.5% Service Charge may be assessed on the unpaid balance of 60 days and over, and also liable for legal and collection fees. I understand that I am responsible for payment in full upon completion of each procedure. My insurance will be billed, if applicable, however, I am responsible for all charges not covered by my insurance.*

_____ _____

*Signature of parent or guardian* *Date*

***(Please complete reverse side)***