MINOR/CHILD REGISTRATION

(PLEASE PRINT)

FAMILY DENTAL
CARE OF FARMINGTON

Phone_____ **PATIENT INFORMATION** Date_____

Name of Minor/Child _____
Last First Initiall

Sex ☐ M ☐ F Age_____ Birthdate_____ Nickname_____ Hobbies_____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____, ome Phone_____ Work Phone_____

Whom may we thank for referring you?_____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone_____ Work Phone_____
(if different from above) (if different from above)

Employer _____

Soc. Sec.# _____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group#_____

Policy#_____

Mother's/Guardian's Name _____

Address (if different from patient's)_____

Home Phone _____ Work Phone_____
(if different from above) (if different from above)

Employer _____

Soc. Sec.# _____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address_____

Group# _____

Policy#_____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance Identification# _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service _____

	YES	NO		YES	NO
Has child complained about dental problems? _____	☐	☐	Is fluoride taken in any form?_____	☐	☐
Does child brush teeth daily? _____	☐	☐	Any injuries to mouth, teeth, head? _____	☐	☐
Does child use floss every day? _____	☐	☐	Any unhappy dental experiences? _____	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc? _____ ☐ ☐

(OVER)

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now? _____	☐	☐
Receiving any medication or drugs? _____	☐	☐
Ever been hospitalized? _____	☐	☐
Ever had surgery? _____	☐	☐
Is there excessive bleeding when cut? _____	☐	☐

Medications _____

Allergies _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF SO PLEASE CHECK (✓)

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian Date

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian Date