Welcome to the Willowbrook Dentistry for Children

PATIENT REGISTRATION & HEALTH HISTORY **TODAY'S DATE:**

TELL US ABOUT YOUR CHILD

Child's Name: ____________________ Nickname/Goes by: ____________________

Last, First MI

Birthdate: ____________ Age: ______ Weight: ______ Male: ____ Female: ____ Child's SSN: ____________

Home Address: ____

School/Grade: ____

Street City State Zip Code

FAMILY INFORMATION

Who is with your child for today's visit? ____________________ Relationship: ____________________

Do you have legal custody of this child? Yes _____ No _____ Is your child adopted? Yes _____ No _____

Parent's Marital Status: Single __ Married __ Separated __ Divorced __ Widowed __ With whom does the child live? ____________________

Names/ages of other siblings we treat: ____

MOTHER/FATHER'S INFORMATION

Name: ____

Mother/Stepmother/Guardian/Other ____________________

Birthdate: ____________ SSN: ____________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ Email: ____________

Employer Name & Address:

____

____

MOTHER/FATHER'S INFORMATION

Name: ____

Father/Stepfather/Guardian/Other ____________________

Birthdate: ____________ SSN: ____________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ Email: ____________

Employer Name & Address: ____________________

____

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____________________ Relationship to Child ____________________

Cell Phone: ____________ Work Phone: ____________ Billing Address: ____________________

PRIMARY DENTAL INSURANCE

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Group # (Policy #) ____________________

Insurance Co. Phone: ____________________

Policy Owner's Name: ____________________

Policy Owner's Birthdate/SSN: ____________________

SECONDARY DENTAL INSURANCE

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Group # (Policy #) ____________________

Insurance Co. Phone: ____________________

Policy Owner's Name: ____________________

Policy Owner's Birthdate/SSN: ____________________

Payment of fees for professional services is expected at time of treatment by parent or guardian in attendance. We can file insurance claims for you and accept assignment of payment to our office. We follow HIPAA privacy rules to keep your information confidential. I have read and understand this form completely and hereby assign/authorize payments and the release of any medical information necessary to secure payment to this office for services rendered on my behalf.

Signature of Parent or Legal Guardian: ____________________ **Date:** ____________

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PATIENT REGISTRATION & HEALTH HISTORY **TODAY'S DATE:**

Child's Name: **DOB:**

DENTAL HISTORY

Is this your child's first visit to the dentist? Yes ___ No ___ Last Visit Date: ___________ Dentist's Name:____

Why did you bring your child to the dentist today? ____

Have there been any injuries to your child's face, mouth, teeth, or chin? ____

Has the child had pain or tenderness in the jaw joint (TMD/TMJ)? Yes _____ No _____

Has the child had difficulty at past dental visits? Yes _____ No _____ Your child's behavior at the dentist is: Good / Fair / Poor

Is the child's drinking water fluoridated? Yes _____ No ____ Your home drinking water is: ☐ City or Town Water ☐ Well Water ☐ Bottled Water

Does the child brush his/her teeth daily? Yes _____ No _____ Floss his/her teeth daily? Yes _____ No _____

If your child has ever experienced any of the following, place a check mark (✓) in the box next to that item:

☐ Clenching/Grinding Teeth ☐ Mouth Breather ☐ Speech Problems

☐ Early Childhood Caries / Tooth Decay ☐ Nail Biting ☐ Thumb/Finger/Pacifier Sucking

☐ Lip Sucking/Biting ☐ Sleeps with a Bottle ☐ Tongue Thrust

Comments:

Does your child require an antibiotic before dental treatment? Yes _____ No _____

MEDICAL HISTORY

Is your child currently under the care of a physician? Yes _____ No _____

Physician's Name: ____ Phone #: ______________________ Date of Last Visit? _________________

Does your child have any **ALLERGIES**? Yes _____ No _____

List all drugs / things your child is allergic to or write "None" ____

List all medications your child is taking at this time or write "None"____

Has your child had an unexpected reaction to Penicillin, Aspirin, Novocain, or any other medication? If Yes, please describe the reaction

____

Has your child ever had any of the following **MEDICAL PROBLEMS** (circle Y for Yes or N for No)?

Y N Abnormal bleeding
Y N ADD / ADHD
Y N Anemia
Y N Any Hospital Stays / Operations
Y N Anxiety/Phobia
Y N Artificial Bones / Joints / Valves
Y N Arthritis
Y N Asthma
Y N Autism
Y N Blood Disease / Blood Disorder
Y N Cancer / Chemotherapy
Y N Chicken Pox / Measles / Mumps
Y N Congenital Heart Defect
Y N Craniofacial Condition (Cleft Lip/Palate)
Y N Diabetes
Y N Difficulty Breathing
Y N Drug / Alcohol Abuse
Y N Eczema
Y N Epilepsy / Fainting / Seizures
Y N Glaucoma
Y N Hearing Impairment
Y N Heart Disease / Heart Murmur
Y N Hepatitis
Y N HIV+ / AIDS
Y N Kidney / Liver Problems
Y N Lactose Intolerance
Y N Oppositional Defiance Disorder (ODD)
Y N Pacemaker
Y N Persistent Cough
Y N Pregnancy
Y N Psychiatric/Psychological Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Sexually Transmitted Disease
Y N Shunt(s)
Y N Special Needs
Y N Tuberculosis
Other: ____
____

Please describe any medical problems your child has had:

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strict 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 all necessary dental services for my child. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in completing this form.

Signature of Parent or Legal Guardian: ____ **Date:** ____

Signature of Dentist: ____ **Date:** ____