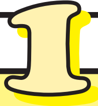
NORTHSIDE DENTAL OFFICE

DENTAL REGISTRATION FORM - CHILDREN



PATIENT INFORMATION

Patient Name: ______________________________ Date: ____________

Address: ______________ ______________ ______________ ______________
City Prov. Postal Code

Phone Home: ______________ Cell: ______________ Work: ______________

Health Card # ______________ ______ Sex: ☐ M ☐ F Age ______ Birthdate ______________
Series

Mother's Name: ______________________________ Occupation: ______________
or Guardian Name

Father's Name: ______________________________ Occupation: ______________

DENTAL INSURANCE

Policy Holder Name: ______________________ Insurance Co.: ______________________

Certificate # ______________________ Group # ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary
Subscriber's Name: ______________________ Insurance Co.: ______________________

Certificate # ______________________ Group # ______________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage

with ______________________ 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 insurance submissions.

______________________ ______________________ ______________
Responsible Party Signature Relationship Date

DENTAL HISTORY

Do you have any concerns for your child? ______________________________

Has your child had previous dental care? ☐ Yes ☐ No Former Dentist: ______________________

Date of last visit: ______________________ Date of last dental x-rays: ______________________

When are your child's teeth brushed?

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime

How often does your child floss?

____

Has your child had local anesthetic before?

☐ Yes ☐ No

Has your child had general anesthetic before?

☐ Yes ☐ No

4 HEALTH HISTORY

Family Physician's Name: ______________________________

Is your child presently under the care of a physician for any ongoing illness? ☐ Yes ☐ No List: ______________________________

____

Has your child ever had a serious illness or been in the hospital ? ☐ Yes ☐ No List: ______________________________

____

Does your child have any known emotional, mental or physical handicaps? ☐ Yes ☐ No List: ______________________________

____

Place a mark on "Yes" or "No" to indicate if your child has had any of the following:

AIDS	☐ Yes	☐ No	Congenital Heart Disease	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Cortisone or Steroid Treatments	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No				Kidney Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Mitral Valve Polapse	☐ Yes	☐ No
			Heart Disease	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Hepatits	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Type ____________			Tuberculosis	☐ Yes	☐ No

Has your child ever been advised that he/she requires medication before having dental treatment? ☐ Yes ☐ No

Is there any other medical information that we should be aware of? ☐ Yes ☐ No

____

____

____

5 MEDICATIONS

List medications you are currently taking:

____

____

____

____

____

____

ALLERGIES

☐ No Known Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Food
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________

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____

6 CONSENT

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Signature: ______________________________ Date: ______________________________