

*This is a fillable form: Please download first, then type your information & print.*

# Pediatric Dentistry and Orthodontic Specialists

## Registration

Child's Name \_\_\_\_\_  
Nick name \_\_\_\_\_ Sex \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Child's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone# \_\_\_\_\_  
School \_\_\_\_\_  
Child's Favorite Activities \_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Mother's DOB \_\_\_\_\_  
Occupation \_\_\_\_\_  
Father's Name \_\_\_\_\_  
Father's DOB \_\_\_\_\_  
Occupation \_\_\_\_\_

Responsible Party \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Email Address \_\_\_\_\_  
Employer \_\_\_\_\_  
Business Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone # \_\_\_\_\_  
Driver's License# \_\_\_\_\_

Have we treated any of your Immediate Family? Y N  
Have we treated any of your Relatives Y N Please List \_\_\_\_\_

Who may we thank for referring you to our practice? \_\_\_\_\_

### Where have you seen or heard about our practice? (please check all that apply)

- Pediatrician \_\_\_\_\_  Your Dentist \_\_\_\_\_  Community Event \_\_\_\_\_  
 Friend/Neighbor \_\_\_\_\_  School Sponsorship/Event \_\_\_\_\_  
 Our website ([www.pdospecialists.com](http://www.pdospecialists.com))  
 Yelp  Facebook  Internet Search  Other \_\_\_\_\_

If you would like us to assist you in filing your insurance claim please complete the following information. If you are the patient receiving care, your insurance is the primary carrier and your spouse's is the secondary. If the patient is a child (dependent), the primary carrier is the parent whose birth month is closest to the beginning of the year.

#### Primary Carrier

Name of Insured \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_  
Employer \_\_\_\_\_  
Group# \_\_\_\_\_ Union/Local \_\_\_\_\_  
Subscriber# \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Relationship \_\_\_\_\_

#### Secondary Carrier

Name of Insured \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_  
Employer \_\_\_\_\_  
Group# \_\_\_\_\_ Union/Local \_\_\_\_\_  
Subscriber# \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Relationship \_\_\_\_\_

#### Emergency Contact Information

Name of Contact \_\_\_\_\_  
Phone Number \_\_\_\_\_

Relationship \_\_\_\_\_

Name of Contact \_\_\_\_\_  
Phone Number \_\_\_\_\_

Relationship \_\_\_\_\_

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity. I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signed (Subscriber/Parent) \_\_\_\_\_

\_\_\_\_\_ Date

# Registration

Child's Name \_\_\_\_\_

**MEDICAL HISTORY**

**yes no office use**

- 1. Does your child have any health problems? .....    
Please elaborate \_\_\_\_\_  
\_\_\_\_\_
- 2. My child is under the care of Dr. \_\_\_\_\_ for the  
following medical condition(s) \_\_\_\_\_  
\_\_\_\_\_ Telephone \_\_\_\_\_
- 3. Is your child currently taking any medications or herbal supplements?    
Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Medicine \_\_\_\_\_ Dosage \_\_\_\_\_
- 4. Does or has your child taken diet enhancers.....
- 5. Is your child allergic to any antibiotics, such as amoxicillin, sulfa or  
other medications?.....    
Specify antibiotic \_\_\_\_\_
- 6. Does your child have a history of allergy or sensitivity to any metals  
(e.g. nickel), latex or any other not mentioned? \_\_\_\_\_
- 7. Has your child had a serious illness?.....    
When \_\_\_\_\_ Type \_\_\_\_\_
- 8. Has your child ever had surgery or been hospitalized? .....    
When \_\_\_\_\_ Why \_\_\_\_\_  
When \_\_\_\_\_ Why \_\_\_\_\_
- 9. Has your child had any heart condition? .....
- 10. Has your child ever had heart surgery? .....
- 11. Is your child subject to nervous disorders? .....    
 Fainting or Dizziness     Seizures     Behavior/learning difficulties  
Does your child have frequent headaches? .....
- 12. Has your child had a history of (check appropriate responses):  
 heart trouble             asthma             cleft lip or palate             cerebral palsy  
 bleeding problem         diabetes             HIV or AIDS                 malignant hyperthermia  
 clotting problem          seizure             bone pathology             congenital birth defect  
 artificial joints             arthritis             liver problem               kidney problem  
 mental retardation         cancer               hearing loss                 eyesight problem  
 speech impediment         infections          drug dependency             other problem not listed

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ DENTIST'S SIGNATURE \_\_\_\_\_

HEALTH HISTORY UPDATE:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date    Parent    Doctor    Date    Parent    Doctor    Date    Parent    Doctor    Date    Parent    Doctor

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_    \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date    Parent    Doctor    Date    Parent    Doctor    Date    Parent    Doctor    Date    Parent    Doctor

Parent

# Medical History

Child's Name \_\_\_\_\_

**DENTAL HISTORY**

**yes no**

office use

- 1. What is the reason for today's visit? \_\_\_\_\_
- 2. Is this your child's first visit to the dentist? .....
- 3. If not, how long since the last visit to a dentist? \_\_\_\_\_
- 4. Previous dentist's name \_\_\_\_\_ in which city? \_\_\_\_\_
- 5. How do you think he/she will act toward the dentist? \_\_\_\_\_
- 6. My child has had x-rays taken prior to this visit. ....
- 7. My child's teeth are brushed \_\_\_\_ times and flossed \_\_\_\_ time per day.
- 8. Is your community water supply fluoridated?
- 9. Do you drink tap water?
- 10. Does your child receive fluoride supplements?    
Drops or tablets    Rinse or gel    Toothpaste
- 11. Have any cavities been noted in the past? .....
- 12. Has your child ever had occlusal sealants? .....
- 13. Has your child received local anesthetic? .....
- 14. Have any teeth been removed by extraction? .....
- 15. Has a space maintaining appliance been placed or recommended?
- 16. My child has sustained a dental injury (falls, blows, chips, etc.) ...
- 17. Does your child have any oral habits (e.g. finger sucking, pacifier?)
- 18. Has your child had an unfavorable experience at another office?    
Please describe \_\_\_\_\_
- 19. Has anyone in the family, including parents, had Orthodontics?    
Who? \_\_\_\_\_
- 20. Has your child been seen by an orthodontist? .....
- 21. Has your child ever worn orthodontic appliances? .....
- 22. Are you personally interested in a referral to an adult general dentist?
- 23. Does your child believe there is anything wrong with his/her teeth?

24. Specific information you would like covered during your child's visit today.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Dental questions you would like to discuss today  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Dental History