MINOR/CHILD REGISTRATION
(PLEASE PRINT)

PEDIATRIC DENTAL ASSOCIATES, P.C.
195 N. Arlington Heights, Rd., Suite 150
Buffalo Grove, IL 60089
Telephone: (847) 537-7695

PLEASE COMPLETE BOTH PAGES

Phone ______________________________

PATIENT INFORMATION

Date ______________________________

Name of Minor /Child ______________________________
Last Name First Name Initial

Sex ☐ M ☐ F Age__________ Birthdate______________ Nickname________________ Hobbies________________

Home Address ______________________________
Street City State Zip

Mailing Address ______________________________
Street City State Zip

Email: ______________________________

Person financially responsible__________________ Home Phone______________ Work Phone______________

Whom may we thank for referring you? ______________________________

Parent's or Guardian's Name ______________________________

Address (if different from patient's)______________________________

____

Home Phone ______________ (if different from above) Work Phone ______________ (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# ______________________________

Parent's or Guardian's Name ______________________________

Address (if different from patient's) ______________________________

____

Home Phone ______________ (if different from above) Work Phone______________ (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
Has child complained about dental problems?______________	☐	☐
Does child brush teeth daily?______________	☐	☐
Does child use floss every day?______________	☐	☐
Is fluoride taken in any form?______________	☐	☐
Any injuries to mouth, teeth, head? ______________	☐	☐
Any unhappy dental experiences?______________	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?______________	☐	☐

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?_______________	☐	☐	Medications ____________________
Receiving any medication or drugs? ____________________	☐	☐	____________________
Ever been hopitalized?____________________	☐	☐	____________________
Ever had surgery? ____________________	☐	☐	Allergies____________________
Is there excessive bleeding when cut?____________________	☐	☐	____________________

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	☐ Kidn ey Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ M ononucleosis	☐ 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, including but not limited to x-rays, and the administration of anesthetics which are deemed necessary by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

____

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 payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of Parent/Guardian Date

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe____

Is patient taking any new medications? _______________ If so, please list ______________________________

Date ________________________ Parent/Guardian Signature ______________________________________

Date ________________________ Dentist Signature ____

UPDATE (To be completed at later visits)

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe____

Is patient taking any new medications? _______________ If so, please list ______________________________

Date ________________________ Parent/Guardian Signature ______________________________________

Date ________________________ Dentist Signature ____