DeWitt Dental Associates Child Registration Form

We would like to welcome and thank you for joining out dental practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest dental care.

PATIENT INFORMATION Date: _____

Child's First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ Birth Date: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Mother's Full Name: _____ Mother's SSN# _____

Mother's Phone Numbers: Home: _____ Cell: _____ Work: _____

Father's Full Name: _____ Father's SSN# _____

Father's Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Can we contact you through email or texting? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Hobbies/Interests: _____

PRIMARY DENTAL INSURANCE:

Insured's Name: _____ Relation: _____ Birth Date: _____

Insured's SS # _____ Insured's Employer: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Policy # _____ Insurance Group Number: _____

SECONDARY DENTAL INSURANCE

Insured's Name: _____ Relation: _____ Birth Date: _____

Insured's SS # _____ Insured's Employer: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Policy # _____ Insurance Group Number: _____

AUTHORIZATION AND RELEASE

I authorize the dentist and staff to perform any necessary services that my child may need during diagnosis and treatment with my informed consent. I authorize the dentist and staff to release any information including diagnosis and records of any treatment or examination rendered to third party payer and/or health practitioners. I authorize and request my dental benefits company to pay directly to the dentist any insurance benefits otherwise payable to me, I understand my dental insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered for myself or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

_____ _____

Parent / Guardian Signature **Date**

DO YOU REQUIRE ANTIBIOTIC PREMEDICATION FOR DENTAL PROCEDURES? ☐ Yes ☐ No

FEMALES: Are you Pregnant? ☐ Yes ☐ No

CARDIOLOGY: Have you had or do you have?

____ Heart Murmur ____ Bacterial Endocarditis ____ Rheumatic Fever

____ Heart Surgery…when? _____ ____ Mitral Valve Prolapse ____ Congenital Heart Defects

____ Artificial heart valve/stents ____ Heart Attack/Stroke ____ High/Low Blood Pressure

Name of Cardiologist: _____Phone:_____

Do you require medication for cardiac conditions? ☐ Yes ☐ No

Please list your current physician:_____ Phone:_____

GENERAL MEDICAL INFORMATION: Have you had or do you currently have:

____ Asthma ____ Diabetes ____ Joint Replacement

____ Hyperactive, ADD, ADHD ____ Thyroid Problems ____ Organ Transplants

____ Cancer/ Tumors/ Leukemia ____ Kidney Problems ____ HIV/AIDS

Type: _____ ____ Bleeding Disorders ____ Hepatitis A, B, C, D, E

____ Chemotherapy or Radiation ____ Anemia ____ Tuberculosis or Positive TB Test

____ Cancer Medication Port ____ Blood Transfusions ____ STD's: Herpes, Syphilis…

____ Vision Challenges/Contacts/Glasses ____ Eating Disorders ____ Hearing Challenges

____ Development Disorder ____ Epilepsy, Seizures ____ Recent Surgeries, explain_____

____ Other: _____ _____

Previous Dentist: _____ Phone: _____ Last Visit: _____

Do you use soda/sports drinks? ☐ Yes ☐ No

If yes, how many per week? _____

Do you have anxiety or fear of dentists? ☐ Yes ☐ No

Do you have dental implants? ☐ Yes ☐ No

Year of placement _____

Do you have a fluoridated water supply? ☐ Yes ☐ No

Do you wear a mouth guard for sports? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you wear a bite splint? ☐ Yes ☐ No

Have you been, or are you currently under the care of an orthodontist? ☐ Yes ☐ No

If yes, please provide name, _____ Phone: _____

Do you have dental concerns? ☐ Yes ☐ No If yes, please explain _____

ALLERGIES:

____ Penicillin products ____ Dental Anesthetics ____ Latex Products ____ Sulfa ____ Seasonal Allergies

____ Codeine ____ Aspirin ____ Bee Sting ____ Tetracycline

Please list any additional: _____

MEDICATIONS: Currently taking Pharmacy Used: _____

_____

_____

All information is accurate to the best of my knowledge:

Signature: _____ Date: _____

Dr. Signature: _____ Date: _____

Updates: (Please Date and Initial)

_____

_____

_____

_____