Child Registration Form

PATIENT INFORMATION

Name:_____ M F Birthdate:_____

Parent/Guardian A:_____Parent/Guardian B:_____

ACCOUNT INFORMATION

Person responsible for this account:_____

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

Cell Phone:_____ Alt Phone:_____ ❑Hm ❑ Wk ❑ Cell

DENTAL INSURANCE INFORMATION

Name of Insured:_____ Date of Birth:_____

Insurance Co:_____ ID#: _____ Group#: _____
Policy Name: (This would be the name of your employer if you have group coverage through them)

_____

DENTAL AND MEDICAL INFORMATION

Is this your child's first visit to a dentist? ❑ Yes ❑ No If not, when was the child's last visit to a dentist?_____

Does your child currently have any dental issues of which we should be aware? ❑ Yes ❑ No If "Yes", please describe:

_____

Is there now or has there ever been any of the following?

❑ Cavities ❑ Toothache ❑ Pain ❑ Broken Tooth ❑Extracted Teeth ❑Straightened Teeth ❑ Gum Infection

How often does your child brush? _____ Floss? _____

Does your child: Suck thumb/finger? ❑ Yes ❑ No Suck or bite lips? ❑ Yes ❑ No Bite or chew nails? ❑ Yes ❑ No
Chew hard objects? (pencils etc) ❑ Yes ❑ No Grind Teeth? ❑ Yes ❑ No Clench Jaws? ❑ Yes ❑ No

Has your child had a history of or difficulty with any of the following?

❑ Anemia	❑ Chicken Pox	❑ Fainting	❑Hepatitis	❑ Rheumatic Fever
❑ Asthma	❑ Convulsions/Epilepsy	❑ Disabilities	❑ Kidney Disease	❑ Sinus Problems
❑ Cancer	❑ Diabetes	❑ Hearing Problems	❑ Liver Disease	❑ Thyroid Disease
❑ Cerebral Palsy	❑ Emotional Problems	❑ Heart Problems	❑ Mononucleosis	❑ Tuberculosis

Does your child have any illness or medical problem not listed above? ❑ Yes ❑ No If "Yes", please list below:

_____

List any medication your child is taking including the dosage:_____
Does your child have any allergies to medications or anything else? ❑ Yes ❑ No If "Yes", please list below:

_____

AUTHORIZATION AND RELEASE

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO FLAWLESS DENTAL INSURANCE BENEFITS FOR SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES WEATHER OR NOT PAID BY INSURANCE. I AUTHORIZE FLAWLESS DENTAL TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF INSURANCE BENEFITS AND TO USE THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Signature of Parent or Guardian:_____ Date:_____