SOUTHERN CONNECTICUT DENTAL GROUP
General, Pediatric & Cosmetic Dentistry

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PEDIATRIC PATIENT REGISTRATION AND HEALTH HISTORY

Date _____ M ☐ F ☐

Child's Name _____ "Nickname" _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Home Phone _____

Number of brothers and sisters (Older) _____ Younger _____

Favorite Activities, TV shows, etc. _____

Name of person financially responsible for the account _____

Whom may we thank for referring you to our office? _____

Is another member of your family or relative a patient at our office? _____ Name? _____

Father's Name _____	Mother's Name _____
Date of Birth _____	Date of Birth _____
Social Security # _____	Social Security # _____
Address if different from child's _____	Address if different from child's _____
City _____	City _____
State _____ Zip _____	State _____ Zip _____
Phone _____ Cell Phone _____	Phone _____ Cell Phone _____
Email _____	Email _____
Employer _____	Employer _____
Business Address _____	Business Address _____
Work Phone _____ Ext. _____	Work Phone _____ Ext. _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____

Do you have dual coverage? Yes ☐ No ☐ if yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Cell Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

DENTAL HISTORY

Reason for visit. (Check-up, Toothache, etc.) _____

Is this the 1st dental visit for this child? (to any dentist) _____ If yes, please skip to next box.

How long ago was last visit? _____

Were previous visits pleasant or unpleasant? _____

Did he/she object to anything in particular? _____

Has your child ever sustained any injuries to the face or teeth? _____ If yes, please describe _____

Does your child have a history of any of the following? Thumb or Finger Sucking _____ Pacifier Sucking _____

Tongue Thrust _____ Mouth Breathing _____ If bottle fed, age bottle discontinued _____

Home water supply (check one) ☐ Public Water ☐ Well Water

Does your child take a fluoride supplement? _____ Use a fluoride rinse? _____

MEDICAL HISTORY

Name of Family Physician or Pediatrician _____ City _____

Is your child in good health? _____ Does he/she take any medication? _____

Has your child ever had any serious illnesses or operations? _____

_____

Has your child ever been admitted to a hospital? _____

Does your child have any allergies to medication? _____ Other allergies? _____

Does your child have a history of any of the following?

Rheumatic Fever	Yes	No	Asthma	Yes	No	Anemia	Yes	No
Heart Disease	Yes	No	Kidney Disease	Yes	No	Seizures	Yes	No
Heart Murmur	Yes	No	Liver Disease	Yes	No	Other (Please Explain)	Yes	No
Diabetes	Yes	No	Bleeding Problem	Yes	No	_____		

Does your child have a handicap or perpetual problem? If yes, please explain _____

_____

FOR FEMALE PATIENTS ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____ Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

The undersigned hereby authorizes Southern Connecticut Dental Group to take x-rays, study models, photographs, or any diagnostic aids appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Southern Connecticut Dental Group to perform any and all forms of treatment, medication, and therapy that may indicated in connection with (Name of Patient) _____ and further authorize and consent that Southern Connecticut Dental Group choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. Balances not paid within 60 days will incur 1 $^{1}/_{2}$% per month (18% annual) interest charge. I further understand that in the event of default (I) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note.

Signature _____ Date _____