Lyme Road Dental, PLLC
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CHILD'S REGISTRATION

For Children 13 and under

Date

Child's name | Nickname | Age | Birthdate

Residence address | City | State | Zip

School | Address | Grade

Father's name | Email Address | Mother's name | Email Address

Father employed by | Home phone | Bus. phone

Mother employed by | Home phone | Bus. phone

Person financially responsible (if other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | Mother's Social Security number

Father's birthdate | Mother's birthdate

Whom may we thank for referring you

What is child's favorite: sport | toy | hobby | person | fictional character

CHILD'S DENTAL HISTORY

	Yes	No
Date of last visit to a dentist		
For what service		
Has child complained about dental problems	☐	☐
Any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.	☐	☐
Any unusual speech habits	☐	☐
Any lost permanent teeth	☐	☐
Have missing teeth been replaced	☐	☐
Orthodontic appliances worn now or ever been	☐	☐
Does your child brush teeth daily	☐	☐
Do you assist child with tooth brushing	☐	☐
How often		
Are disclosing tablets used	☐	☐
Is fluoride taken in any form	☐	☐

Summary: (for doctor's use)

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No		Yes	No
Is child under care of physician now _____	☐	☐	Is there any allergy to penicillin or other drugs _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐	Are there other allergies: food-pollen-animals-dust-other	☐	☐
Is there any excessive bleeding when cut _____	☐	☐	Does child have good physical coordination _____	☐	☐
Has child ever been hospitalized _____	☐	☐	Are there any emotional problems _____	☐	☐
Has child ever had surgery _____	☐	☐	Other health related comments _____		

Has child any history of or difficulty with any of the following:

_Anema	_Chronic sinus	_Hearing	_Mastoid	_Thyroid
_Asthma	_Convulsions	_Heart	_Measles	_Tuberculosis
_Bladder	_Diabetes	_Kidney	_Mononucleosis	_Venereal disease
_Cerebral Palsy	_Other	_Liver	_Mumps	_Thyroid
_Chicken pox	_Fainting	_Malignancies	_Rheumatic fever	_Thyroid

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

_____

	Yes	No
May we request release of your child's medical records for our reference _____	☐	☐

This information was discussed with and given by _____

Relation to child _____

INSURANCE INFORMATION

Name of Subscriber _____ Relationship to Patient _____

Address _____ Subscribers Date of Birth _____

_____ Social Security # _____

Subscribers Employer _____ Phone # _____

Address _____

Name of Insurance Company _____ Group or Other ID # _____

Phone Number _____ Secondary insurance coverage, if any _____