Fort Worth Children's Dentistry

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Patient's Registration and History

Date: _____

Child's Name _____ Age _____ Date of Birth _____

Prefers to be called _____ Sex _____ Weight _____

What other children in your family have we seen? _____

Who referred your child to our office? _____

Pediatrician (physician) _____

I. CHILD'S MEDICAL HISTORY:

	Yes	No
1. Does your child have any known physical disorder?	☐	☐
2. Does your child have any allergies (penicillin, asthma, etc.)?	☐	☐
What: _____		
3. Is your child receiving any medications now?	☐	☐
What: _____		

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

___ Anemia/Sickle Cell	___ Cerebral Palsy	___ Fainting	___ Lung Disease	___ Thyroid Disorders
___ Asthma	___ Convulsions	___ Hearing/Speech Disorder	___ Malignancies	___ Tuberculosis
___ Autism	___ Diabetes	___ Heart Disorders	___ Mental Retardation	___ Vision Disorders
___ Bladder Disease	___ Epilepsy	___ Hepatitis	___ Pregnancy	___ Transfusions
___ Blood Disorders	___ Emotional or	___ Kidney Disorders	___ Rheumatic Fever	___ AIDS
___ Bleeding Disorders	Behavioral Disorder	___ Liver Disease	___ Sinus Problems	___ HIV Positive

___ Other (Please Explain) _____

_____

_____

II. CHILD'S MEDICAL HISTORY:

	Yes	No
1. Has child had any unfavorable dental experiences?	☐	☐
2. Has child had any injuries to the mouth or teeth?	☐	☐
3. Does child have a toothache now?	☐	☐
4. Does child have any mouth habits? (thumbsucking, pacifier, etc.)	☐	☐
5. Last dental examination / x-rays _____		

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child. _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

OVER

III. GENERAL INFORMATION:

Parent or Guardian responsible for this account:

Father _____ (Full Name) Mother: _____ (Full Name)

Birth Date: _____ Birth Date: _____

SS#: _____ SS#: _____

Cell #: _____ Cell #: _____

Email: _____ Email: _____

☐ Married ☐ Separated ☐ Divorced ☐ Single

Address _____

City _____ State _____ Zip _____ Home Telephone _____

In case of emergency whom may we contact (Name, relationship, phone). _____

_____

List other names to whom we may release information: _____

_____

Place of employment and occupation:

Father: _____ Work Phone _____

Mother: _____ Work Phone _____

Dental Insurance Information:

Policy Holder's Name: _____ DOB _____ SS# _____ Relationship _____

Dental Insurance Company's Name: _____ Employer_____

Group #: _____ Phone _____

All fees for services rendered are payable at the conclusion of each appointment unless other financial arrangements have been made. I agree to be responsible for payment of all services rendered for this child. If applicable I authorize my Insurance Company to pay directly to Dr. Morrow, Dr. Jamison and/or Dr. Beville. I understand that my dental insurance carrier may pay less than the actual bill for services and that I am responsible for the balance.

IV. CARE OF PARENTS:

At the first visit the teeth are cleaned then x-rayed for children over 3 years of age. If the child is suffering from a toothache, emergency treatment will be provided. No fillings or extractions will be done on the child's first visit. An account of the services to be rendered and cost of the complete case will be given to the parent before any treatment is begun.

In providing dental care, we will treat your child as we would our own. Numbing agents and dental gas are used routinely to help overcome the fear of dental care. Dentistry is an important health service for your child, and we will attempt to provide your child a satisfying experience in our office.

V. CONSENT FOR TREATMENT OF A MINOR:

The undersigned herby authorizes Dr. Morrow, Dr. Jamison and/or Dr. Beville to perform the examination including x-rays, and after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in force and effect until cancelled by either party.

Signed _____

Relationship _____ Date _____