

CHILD REGISTRATION

Child's Name _____ Date _____

Birthdate _____ Age _____

Nickname _____ Hobbies _____

Parent's Name _____

Single _____ Married _____ Divorced _____ Widowed _____

If divorced, with whom does the child live? _____

Residence-street _____

City _____ State _____ Zip _____

School _____

Home Telephone _____ School _____

Father Employed by _____ Position _____

Mother employed by _____ Position _____

Who will pay this account? _____ email address _____

Purpose of visit _____

Name of father's dental insurance co _____

Policy number _____

Name of mother's dental insurance co _____

Policy number _____

Parent's Social Security numbers:

Father _____ Mother _____

Parents' birthdates:

Father _____ Mother _____

INFORMATION FOR EMERGENCY TREATMENT

Date of last medical examination _____

Does child have or has child ever had:	Yes	No
Anemia.....	_____	_____
Diabetes.....	_____	_____
Hepatitis.....	_____	_____
Allergies.....	_____	_____
To penicillin.....	_____	_____
To local anesthetic.....	_____	_____
Abnormal heart condition.....	_____	_____
Abnormal bleeding from a cut.....	_____	_____
Rheumatic Fever.....	_____	_____
Heart Murmur.....	_____	_____
Is your child under the care of a physician now.....	_____	_____
Is any medication being taken.....	_____	_____
If so, what _____		

Other physical conditions _____		

Name of physician _____

Telephone number _____

Information given by (signature) _____

Date	Service Rendered	Charge	Credit	Balance