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WELCOME TO BAYVILLE DENTAL
~CHILD REGISTRATION~

Date _____

PATIENT INFORMATION...

First Name _____ Middle _____ Last Name _____

Nickname _____ Sex: ❑ Male ❑ Female Birth Date _____ **Age** _____

Address Child Resides: _____ Apt. _____

City _____ State _____ Zip _____

List the names and ages of the child's sibling(s) _____

What are the child's hobbies, pets, favorite TV shows _____

Whom may we thank for referring you? _____

Reason for this visit (first exam, check-up, toothache, etc.) _____

PARENT 1/GUARDIAN INFORMATION...

Name _____ _____
FIRST NAME LAST NAME

Home Address (if different from child) _____

Home Tel. (____) _____ Cell. (____) _____

Work Tel. (____) _____ Extension _____ Occupation _____

E-Mail _____

Is there any additional parent/guardian information of which we need to be made aware? ❑ Yes ❑ No

If Yes, please explain

PARENT 2/GUARDIAN 2 INFORMATION...

Name _____ _____ Relationship to Child _____
FIRST NAME LAST NAME

Home Address (if different from child) _____

Home Tel. (____) _____ Cell. (____) _____

Work Tel. (____) _____ Extension _____ Occupation _____

E-Mail _____

DENTAL HISTORY...

Does your child do any of the following:

❑Brushes with fluoridated toothpaste
❑Takes fluoride supplements
❑Brushes with help from an adult
❑Eats or drinks after brushing at night
❑Drinks only bottled water
❑Drinks juice
❑Drinks sports drinks
❑Child falls asleep with milk or juice
❑Child uses a bottle with milk or juice
❑Child uses a sippy cup
❑Nursing during the day
❑Nursing to sleep
❑Nursing on demand
❑Chewing objects
❑Nail biting
❑Grinding
❑Thumb sucking
❑Finger sucking
❑Lip sucking
❑Pacifier
❑Mouthbreather
❑Snores

DENTAL HISTORY CONT...

Please describe any dental problems your child may have that concerns you

Is this your child's first dental visit? ❑ Yes ❑ No

If not when was the last dental visit_____, with whom _____

Was the dental experience pleasant? ❑ Yes ❑ No; if no, please elaborate

_____

Has your child had any dental x-rays before? ❑ Yes ❑ No; if yes, when_____

Has your child ever had a procedure with ❑ Numbing ❑ Laughing gas ❑ Not applicable

Have there been any injuries to the teeth, lips, mouth, chin, or face? ❑ Yes ❑ No; if yes please describe the injury and when it occurred

Is there a family history of missing or extra teeth? ❑ Yes ❑ No

MEDICAL HISTORY...

Your child's physician's name_____ Physician's tel. (____) _____
FIRST NAME LAST NAME

Allergies (food, drug, seasonal, other)

Is your child in good health_____

If your child has been treated in a hospital or emergency room within the past two years please explain:

_____

Please check each box for any history of conditions or experiences:

❑ADHD
❑Anemia
❑Auto-immune disease
❑Arthritis
❑Asthma / reactive airway
❑Autism spectra
❑Behavioral disorder
❑Bleeding disorder
❑Brain / nerve disorder
❑Cancer
❑Celiac disease
❑Crohn's disease
❑Developmental delays
❑Diabetes
❑Ear problems (chronic)
❑Eating or feeding disorder
❑Epilepsy
❑Genetic disorder
❑Head injuries
❑Heart murmur
❑Heart problems
❑Hepatitis / liver problems
❑Hormone problems
❑Intellectual disability
❑Kidney / bladder disorder
❑Low muscle tone
❑Reflux
❑Rheumatic fever
❑Sensory processing disorders
❑Speech / language delays

Please elaborate on any of the checked items above as necessary:

If there are any other medical conditions we should be aware of please describe:

_____

Please list any medications or vitamins your child is taking:

Please explain any sensory issues (smells, tastes, sounds, textures):

_____

AUTHORIZATION FOR TREATMENT OF A MINOR

ONLY those persons listed below (excluding anyone with legal guardianship) are authorized to bring your child to their dental appointments and make decisions regarding the treatment rendered. If anyone other than those listed below brings the child, the appointment may be rescheduled. Regardless of who brings the child, I am still responsible for the financial payments on this account. I, as the legal guardian, am responsible for making changes regarding the persons I am authorizing on this form.

First Authorized Name _____ **Relationship to Child** _____

Second Authorized Name _____ **Relationship to Child** _____

MEDICAL RELEASE

I give permission to my Pediatrician, Healthcare Provider, or Specialist to provide medical information regarding my child including, but not limited to: medications, allergies, and diagnoses

❑ **Accept** ❑ **Deny**

ACKNOWLEDGEMENTS

❑ By checking this box, I indicate I have had an opportunity to review a copy of this office's Notice of Privacy practices and will be provided a personal copy upon request.

❑ By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the doctors of any changes in my child's health as soon as possible. I hereby authorize treatment by the doctors caring for my child.

❑ By checking this box, I agree to pay at time of service in consideration for the professional services rendered by this office and I consent and agree to be financially responsible for payment of all services provided on behalf of my dependents.

❑ By checking this box, I acknowledge that all of the preceding information provided is true and correct. I understand it is my full responsibility to inform the doctors if my child has a change in their health or medications. This serves as my electronic signature for the Patient History Form.

Parent / Guardian / Self Signature _____

Relationship to Child _____ **Response Date** _____