CHILD'S REGISTRATION FORM

Child's Name _____

Nickname _____ Age _____ Sex M / F

Date of Birth _____/_____/_____ Today's Date _____/_____/_____

Child's Physician _____

Name of School Attending _____

Is child taking any medications? ..... Yes No

Please list _____

Is the child sensitive or allergic to anything? ..... Yes No

If so, please specify: _____

Has child experienced any unfavorable reaction from any previous dental or medical care? ..... Yes No

Has child lived or been living in an area where water supply was fluoridated? ..... Yes No

History of heart trouble, rheumatic fever, epilepsy, HIV, Tuberculosis, diabetes, bleeding, or mental disorders? If yes, underline. ..... Yes No

Special needs due to mental retardation, Down's Syndrome, Cerebral Palsy, ADHD, bi-polar disorder, autism? ..... Yes No

Is child in good health? ..... Yes No

Adolescent females – pregnant? ..... Yes No

If so, how many months? _____

Please use reverse side for any additional information regarding child's history.

Parent or Guardian _____ Date of Birth _____/_____/_____

Social Security # _____/_____/_____ Drivers License # _____

Residence Address _____ Phone(_____) _____

Apt # _____ City _____ State _____ Zip _____

Employer _____

Business Address _____ Phone (_____) _____

City _____ State _____ Zip _____

Referred by _____

Will you be using insurance? ❑ Yes ❑ No

RESPONSIBLE PARTY INFORMATION (If different from front)

Responsible Party Name ______________________________

Relationship to Patient ______________________________

Date of Birth ________/________/________

Social Security # ________-______-________ Drivers License # ______________________

Home Address ______________________________

Apt # __________ City ______________ State ____________ Zip __________

Employer ______________________________

Business Address ______________________________

City ______________________ State ____________ Zip __________

Business Phone (________)______________________

Emergency Contact ______________ Phone (______)______________ Relationship to Patient __________

Additional Information ______________________________

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To the best of my knowledge, these questions have been answered accurately. It is my responsibility to inform the dental office of any changes in medical status.

Signature ______________________________ Date ______________

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I, ______________________________, give consent for ______________________________
(Parent or Gurardian) Patient

to receive dental treatment and authorize Dr. Tennison to provide these diagnostic and preventative services: a dental examination, dental xrays, teeth cleaning, fluoride treatment or sealants.

Signature ______________________________ Date ______________