PRINT THIS FORM

PeterBreen DMD

Patient Registration (for child under the age of 14)

Child's Name: LAST / FIRST / MIDDLE			
Child's Nickname:	Date of Birth:	Sex: M ○	F ○
Names and Ages of Siblings:			
Pets (type and name):			
Address: MAILING ADDRESS	City:	State:	Zip:
Home Phone (with area code):	Email:		
Who may we thank for referring you?:			
Pediatrician:	City:	Phone:	
Previous Dentist:	City:	Phone:	
Parent's Name: LAST / FIRST / MOBILE PHONE (with area code)			
Employer:	Current Position:		
Parent's Name: LAST / FIRST / MOBILE PHONE (with area code)			
Employer:	Current Position:		

Dental Insurance Information

Primary Insurance Information			
Name of Subscriber:	Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other		
Subscriber's Social Security Number:	Subscriber's Date of Birth:		
Subscriber's Employer:			
Employer Address: EMPLOYER MAILING ADDRESS	City:	State:	Zip:
Insurance Company:			
Insurance Co. Address: INSURANCE COMPANY MAILING ADDRESS	City:	State:	Zip:
Id #:	Group #:		

Secondary Insurance Information			
Name of Subscriber:	Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other		
Subscriber's Social Security Number:	Subscriber's Date of Birth:		
Subscriber's Employer:			
Employer Address: EMPLOYER MAILING ADDRESS	City:	State:	Zip:
Insurance Company:			
Insurance Co. Address: INSURANCE COMPANY MAILING ADDRESS	City:	State:	Zip:
Id #:	Group #:		

PRINT THIS FORM

PeterBreen DMD

Dental Information For the following questions, mark (X) your responses.

Click "DK" if you don't know the answer	YES	NO	DK	
Is this your child's first visit to the dentist?	○	○	○	If yes, date of last visit: .....
Have dental radiographs been taken?	○	○	○	If yes, date: .....
Do you help brush?	○	○	○	How often are your child's teeth brushed? .....
Do you help floss?	○	○	○	How often is floss used? .....
Is your drinking water flouridated?	○	○	○	
If not, does your child receive flouride supplements?	○	○	○	
Did your child ever take a bottle or sippy cup to bed?	○	○	○	

What other dental procedures has your child had?

What was your child's reaction to those procedures?

Describe your child's temperment and probable reaction to dental treatment:

Reason for your visit today:

Please describe the parents history of dental decay: ..... Mother: ○ HIGH ○ AVERAGE ○ LOW Father: ○ HIGH ○ AVERAGE ○ LOW

Does your child have any habits which might affect the mouth or teeth (check all that apply)?

- ☐ Breathes through mouth
- ☐ Tongue thrust/habit
- ☐ Sucks thumb or fingers
- ☐ Pacifier - If checked, until what age?

Medical Information For the following questions, mark (X) your responses.

Click "DK" if you don't know the answer	YES	NO	DK
Has your child been seen by a physician during the last 12 months?	○	○	○
Is your child under medical care at present?	○	○	○
If Yes, please explain:			
Does your child have any possible or confirmed food allergies?	○	○	○
Medication: Food: Other:			
Is your child taking any medication now?	○	○	○
What Medication: Why:			
Has your child ever been hospitalized?	○	○	○
When: Why:			
Has your child had any operations?	○	○	○
When: Why:			
Has general anesthetic ever been administered to your child?	○	○	○
If yes, please describe any complications:			
Does your child bruise easily?	○	○	○
Has your child ever bled escessively from a cut or injury?	○	○	○

Has your child ever had any of the following (check all that apply)?

☐ Heart Disease	☐ Liver Disease	☐ Diabetes	☐ Rheumatic Fever	☐ Kidney Disease
☐ Seizures	☐ Heart Murmur	☐ Hepatitis	☐ Anemia	☐ Asthma
☐ HIV	☐ Learning disabilities	☐ Emotional disabilities	☐ Hearing or Speech difficulties	

Please elaborate:

How does your child accept his/her pediatrician?

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. *I authorize any provider to release any information regarding the dental history, treatment or benefits payable for any treatment to any authorized agent for purposes of determining benefits payable. I authorize payment directly to dentist for services rendered.

Signature of Patient/Legal Guardian: _____ Date: _____