HERRICK DENTAL CARE
REGISTRATION FORM

(Please Print)

Today's date:	E-Mail:

CHILD'S INFORMATION

Patient's last name: First: Middle:	Birthday: / /	Age:	❑ M ❑ F
Nickname:	School:		Grade:
Other family members seen here:			

PARENT INFORMATION

Parents's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:	Social Security no.:		Home phone no.: ( )
City:	State:	Zip:	Cell no.: ( )
Occupation:	Employer:		Employer phone no.: ( )
Do you have legal custody of the child? ❑ Yes ❑ No	Whom may we thank for referring you?	Child's previous dentist:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	ID or SS: Group no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

Why did you bring the child to the dentist?
_____
_____

Has the child ever had a serious/difficult problem associated with previous dental visits? Y N

Is the child's water fluoridated? Y N

Is the child taking fluoridated supplements? Y N

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD) Y N

Does the child brush his/her teeth daily? Y N

Childs Physician: _____
Phone#_____
Date of last visit:_____

Is the child currently under the care of a physician? Y N
Please describe the child's physical health:
__Good __Fair __Poor

Please list all drugs the child is currently taking:
_____
_____
_____

Please list all drugs the child is allergic to:
_____
_____
_____

Please list any serious medical problems that the child has had:
_____
_____

Y N Lip sucking/Biting
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Thumb/Finger Sucking
Y N Was the child breast fed?

Has the child ever had any of the following medical problems?
Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Anemia
Y N Any Hospital Stays
Y N Any Surgeries
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Exposed to HIV/but Neg.
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Hemophilia
Y N Hepatitis
Y N Hives
Y N HIV Positive
Y N Immunizations Current
Y N Kidney/Liver Problems
Y N Measles
Y N Mononucléoses
Y N Rheumatic/Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)
Y N Anything you would like to discuss with the doctor in private

I have reviewed the medical/dental information above with the parent/guardian and patient herein.
_____ Initials _____ Date

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDC and the ADA

I understand that the information that I have given is correct to the best of my knowledge, that it be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____ _____
Signature **Date**