

Date:

CHILD PATIENT REGISTRATION

Patient's Name _____ Birth date _____ Sex M F
 Address Street _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Email Address _____ Work Phone _____
 Would you like to receive text message or email reminders? Text Email Both No
 Whom may we thank for referring you? _____
 Parent/Guardian's Name _____ Sex M F
 Parent/Guardian's Address Street _____ City _____ State _____
 Zip _____ Home Phone _____ Cell Phone _____

PERSON RESPONSIBLE FOR THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name _____ Birth date _____ Sex M F
 Street Address (If different) Street _____ City _____ Zip _____
 Home Phone _____ Cell Phone _____
 Email Address _____ Work Phone _____
 Responsible Party's Employer _____ No. Yrs. Employed _____
 Business Address _____ Soc. Sec. No. _____
 Drivers License # _____ Expiration Date _____

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name _____ Birth date _____
 Soc. Sec. No. _____ Subscriber's Employer _____
 Business Address _____ Insurance Co. _____
 Group No. _____ Deductible Yes No
 Patient's Relationship to Subscriber: Self Spouse Dependent Have you used your dental insurance previously? Yes No
 Are you covered under more than one dental plan? Yes No *If yes, please fill out the next section.*

SECONDARY INSURANCE

Subscriber's Name _____ Birth date _____
 Soc. Sec. No. _____ Insurance Co. _____
 Group No. _____ Employer _____ Relationship to Patient _____

I authorize payment directly to Plymouth Dental Associates of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I authorize the Plymouth Dental Associates to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Parent or Guardian's Signature _____

CHILD'S MEDICAL HISTORY

Child's general health: Excellent Good Fair Poor Is your child under care of physician now? Yes No

Physician's Name _____ Phone _____ Last Physical _____

Physician's Address _____

Is your child receiving any medication now? Yes No If so, for what purpose? _____

Has your child ever been treated (other than diagnostic) with x-ray? Yes No

Is your child allergic to any of the following: Penicillin Codeine Local Injected Anesthetics

Is your child allergic to any of the following: Food Pollen Animals Milk Other _____

Is your child subject to prolonged bleeding? Yes No

Does your child have good physical coordination? Yes No

Had your child had any history or difficulty with any of the following:

__ Acid Reflux	__ Fainting	__ Mononucleosis
__ Anemia	__ Glaucoma	__ Rheumatic Fever
__ Asthma or Hay Fever	__ Hearing	__ Sinus Trouble
__ Abnormal Blood Pressure	__ Heart Disease	__ Thyroid
__ Bladder	__ Heart Murmur	__ Tuberculosis
__ Cerebral Palsy	__ Hepatitis	__ Ulcers
__ Chronic Sinus	__ Jaundice	__ Serious Accident
__ Congenital Heart Lesions	__ Kidney Disease	__ Emotional Problems
__ Cough	__ Malignancies	__ Other conditions not listed _____
__ Diabetes	__ Mastoid	_____
__ Epilepsy	__ Measles	_____

Please describe any current medical treatments, including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been discussed: _____

CHILD'S DENTAL HISTORY

Date of last dental visit? _____ Dentist's Name _____ Phone _____

Did your child have x-rays taken? Yes No

Has your child had all of their teeth x-rayed in the past 3 years? Yes No

Has your child complained about dental problems? Yes No

Has your child had any unhappy dental experiences? Yes No

Has your child had any injuries to the mouth, teeth, or head? Yes No

Has your child ever worn orthodontic appliances? Yes No

Do your child have any mouth habits? (i.e. thumb sucking, nail biting, mouth breathing, etc.) Yes No

Does your child clench or grind teeth during the day or night? Yes No

Does your child have any unusual speech habits? Yes No

Does your child brush their teeth daily? Yes No Do you assist with tooth brushing? Yes No

Is dental floss used?..... Yes No Is fluoride taken in any form? Yes No

What is your child's attitude toward dentistry? _____

Do you desire complete dental service for your child? Yes No

Please add anything else that you feel is important for the doctor to know _____

I authorize treatment at Plymouth Dental Associates and accept responsibility for payment.
Parent or Guardian's Signature _____