Children's Dentistry
AT ODENTON
1215 Annapolis Road, Suite 106, Odenton MD 21113
410-672-1100

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Pediatric Dental Specialist

# REGISTRATION & HEALTH HISTORY

**DATE**________________

## TELL US ABOUT YOUR CHILD

Name_______________________________________
Last First MI
Nickname _________________ Male Female
Child's Social Security #_____________________
Child's Birthdate ____/_____/_____ Age ________
Child's Address_________________________________
_______________________________________________
Child's Phone # _________________________________
Parent responsible for Account _________________

**Mother** Stepmother Guardian
Name ___________________________________________
Address (if different from child) ________________
_________________________Home # ________________
SS# _____________________ DL# _________________
Work# __________________ Cell# ________________
Email ___________________________________________
Employer ________________________________________
Address _________________________________________

**Father** Stepfather Guardian
Name ___________________________________________
Address (if different from child) ________________
______________________________Home # __________
SS# _____________________ DL# _________________
Work # __________________ Cell# ________________
Email ___________________________________________
Employer ________________________________________
Address _________________________________________

## GENERAL INFORMATION

Who is accompanying the child today?__________
_______________________________________________
Relationship ____________________________________
Do you have legal custody? Yes No
Who may we thank for referring you?___________
_______________________________________________
Parent Marital Status: Single Married
Divorced Separated Partnered

**PRIMARY DENTAL INSURANCE**

Insurance Name _________________________________
Insurance Address _______________________________
_______________________________________________
Insurance Phone # _______________________________
Group # _________________________________________
Policy # _________________________________________
Policy Owner's Name _____________________________
Relationship to Patient __________________________

**SECONDARY DENTAL INSURANCE**

Insurance Name _________________________________
Insurance Address _______________________________
_______________________________________________
Insurance Phone # _______________________________
Group # _________________________________________
Policy # _________________________________________
Policy Owner's Name _____________________________
relationship to Patient __________________________

## ACKNOWLEDGEMENT AND AUTHORITY

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any or all necessary dental services can be rendered. I understand that the information I have given is correct, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize Children's Dentistry at Odenton to perform the necessary dental services my child may need. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF ALL SERVICES RENDERED ON MY DEPENDENT'S BEHALF, IN FULL, AT THE TIME OF SERVICE.

_______________________________________________________________
Parent/Legal Guardian Signature Date

**MEDICAL HISTORY**

| | | |
|---|---|---|
| Is your child under the care of a physician? | YES | NO |

Name of Physician? ______________________ Phone # ______________________

Please describe the child's current physical health. (Please circle)

GOOD FAIR POOR

Please list any drugs your child is currently taking? ______________________

Any drug allergies? Please list ______________________

Any food allergies? ______________________

| | | |
|---|---|---|
| Is your child allergic to latex? | YES | NO |

Has your child has/had any history of the following: (Please check)

| | | |
|---|---|---|
| Abnormal Bleeding/Hemophilia | ADD/ADHD | AIDS/HIV |
| Anemia | Asthma | Autism |
| Cancer | Cerebral Palsy | Convulsions |
| Diabetes | Disabilities/Special Needs | Drug/Alcohol Abuse |
| Epilepsy | Fainting | Hearing Problems |
| Heart Problems | Hepatitis | Kidney Disease |
| Liver Disease | Pregnancy | Sinus Problems |
| Thyroid Problems | Tuberculosis | |

Hospitalizations/Operations ______________________

**DENTAL HISTORY**

Why did you bring your child today? ______________________

| | | |
|---|---|---|
| Is your child currently in pain? | YES | NO |
| Is your child taking any medications for pain? | YES | NO |
| Is this your child's first dental visit? If no, state last visit. ______________ | YES | NO |
| Does your child require any antibiotics before dental treatment? | YES | NO |
| Has your child ever had any injury to his/her teeth, mouth, head or jaws? | YES | NO |
| Has your child ever had any unpleasant dental experience? | YES | NO |
| Does he/she like to brush daily? | YES | NO |
| Do you help brush his/her teeth? | YES | NO |
| Morning Between Meals Night | | |
| Does he/she floss? | YES | NO |
| Is the child's water fluoridated? | YES | NO |
| Is the child taking fluoride supplements? | YES | NO |
| Has the child ever had fluoride treatment at his/her doctor? | YES | NO |

Child's Existing Habits (Please check)

| | |
|---|---|
| Breast Feed | Thumb/Finger Sucking |
| Night time Feeding | Lip/Cheek Sucking |
| Sippy Cup Use | Tongue Thrust |
| Pacifier (over 2 years) | Mouth breather |
| Grinding of Teeth | |

| | | |
|---|---|---|
| Does your child play any sports? | YES | NO |
| Does he/she wear a mouthguard? | YES | NO |