EARNEY DENTAL ASSOCIATES, INC.

CHILD'S REGISTRATION AND HISTORY

DATE _____

CHILD'S NAME _____ (LAST) _____ (FIRST) NICKNAME _____

SCHOOL _____ GRADE _____ AGE _____ DATE OF BIRTH _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (AREA CODE) _____

FATHER'S NAME _____ MOTHER'S NAME _____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____

RELATIONSHIP TO CHILD _____ PHONE _____ (AREA CODE + NUMBER)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHEN DENTAL INSURANCE COVERAGE - NAME OF CARRIER _____

EMPLOYER _____ WORK PHONE _____ SS# _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU _____

WHAT IS CHILD'S FAVORITE SPORT _____ FAVORITE TOY _____

FAVORITE HOBBY _____ FAVORITE PERSON _____ FAVORITE FICTION CHARACTER _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____

	YES	NO
Has child complained about dental problems _____	☐	☐
Any unhappy dental experiences _____	☐	☐
Any injuries to mouth - teeth - head _____	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	☐	☐
Any unusual speech habits _____	☐	☐
Any lost teeth _____	☐	☐
Have missing teeth been replaced _____	☐	☐
Orthodontic appliances worn now or ever been _____	☐	☐

	YES	NO
Does your child brush teeth daily _____	☐	☐
Do you assist child with tooth brushing _____	☐	☐
How often _____		
Is dental floss used _____	☐	☐
How often _____		
Are disclosing tablets used _____	☐	☐
Is fluoride taken in any form _____	☐	☐

Child's attitude to dentistry _____

Do you desire discussion of complete dental service for the child _____ ☐ ☐

Summary (for doctor's use) _____

CRH-435

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO		YES	NO
Is child under care of physician now _____	☐	☐	Does child have good physical coordination _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐	Are there any emotional problems _____	☐	☐
Is there any excessive bleeding when cut _____	☐	☐	Summary (for doctor's use) _____		
Has child ever been hospitalized _____	☐	☐			
Is there any allergy to penicillin or other drugs ____	☐	☐			
Are there other allergies: food-pollen-animals-dust-other	☐	☐			

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia	___ Convulsions	___ HIV	___ Mumps
___ Asthma	___ Diabetes	___ Kidney	___ Rheumatic Fever
___ Bladder	___ Epilepsy	___ Liver	___ Thyroid
___ Cerebral Palsy	___ Fainting	___ Malignancies	___ Tuberculosis
___ Chicken Pox	___ Hearing	___ Mastoid	___ Other
___ Chronic Sinus	___ Heart	___ Measles	___ Venereal Disease
	___ Hepatitis	___ Mononucleosis	

SUMMARY: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed. List all medication presently taking. This is important as some medications we may want to use may interact with medications you are taking.

_____

_____

_____

	YES	NO
May we request release of your child's medical records for our reference _____	☐	☐

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Date_____ Your Signature_____

This information given by _____

Relation to child _____

A ×nance charge of 18% APR will be added to outstanding accounts past 60 days.

Our of×ce is fully committed to compliance with HIPAA guidelines by appropriately maintaining our patient information and billing processes in a secure and private manner in compliance with national standards.