Honolulu Endodontics, Inc.

Welcome. Our goal is to make your visit as pleasant as possible. Please fill out this form completely so we can serve you better.

Today's Date: _____

Child Registration Information

Child's Name: ❑ Mstr. ❑ Miss. _____
(check one) First Middle Initial Last

Nickname: _____ Birthdate: _____ Age: _____

Address: _____
Street City, State Zip Code

Phone numbers: Home: _____ Other: _____

School: _____ Grade: _____ Address: _____

Referral Information

Whom may we thank for referring you here? _____ Your Dentist's Name: _____

Parent's Information

Father's Name: _____ Birthdate: _____
First Middle Last

Social Security #: _____ Home Phone: _____ Work Phone: _____

Address: _____
Street City, State Zip Code

Father Employed By: _____ How Long: _____

Mother's Name: _____ Birthdate: _____
First Middle Last

Social Security #: _____ Home Phone: _____ Work Phone: _____

Address: _____
Street City, State Zip Code

Mother Employed By: _____ How Long: _____

Person Responsible for Account (if other than parent): _____

Relationship to child: _____ Social Security #: _____ Home Phone: _____

Address: _____
Street City, State Zip Code

Insurance Information

Primary Dental Insurance Carrier Name: _____ Group#: _____

Insurance Company Address: _____
Street City, State Zip Code

Insurance Company Phone: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Relationship to Child: _____ Employer: _____

Secondary Dental Insurance Carrier Name: _____ Group#: _____

Insurance Company Address: _____
Street City, State Zip Code

Insurance Company Phone: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Relationship to Child: _____ Employer: _____

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Child Medical History

In case of emergency contact: _____ Work #: _____ Home #: _____

Relationship to Child: _____

Personal Physician: _____ Phone: _____

Child's current physical health is: Good ____ Fair ____ Poor ____

Is Child currently under physician's care? _____ If so, for what? _____

Please list any medications the child is taking: _____

Has your child has an unfavorable experience in a previous dental (or medical) office? ☐ Yes ☐ No

Please check if the child has ever had any of the following diseases or medical problems?

☐ Anemia	☐ Epilepsy/Seizures/Fainting Spells	☐ Pacemaker
☐ Arthritis	☐ Fever Blisters/Cold Sores/Herpes	☐ Psychiatric Problems
☐ Artificial Bones/Joints	☐ Glaucoma	☐ Radiation Treatment
☐ Artificial Valves	☐ Heart Attack	☐ Rheumatic Fever
☐ Asthma	☐ Heart Murmur	☐ Scarlet Fever
☐ Blood Transfusion	☐ Heart Surgery	☐ Severe/Frequent Headaches
☐ Cancer/Chemotherapy	☐ Hemophilia/Abnormal Bleeding	☐ Shingles
☐ Colitis	☐ Hepatitis	☐ Sinus Problems
☐ Congenital Heart-Defect	☐ High Blood Pressure	☐ Stroke
☐ Diabetes	☐ HIV+/ AIDS	☐ TB
☐ Difficulty Breathing	☐ Kidney Problems	☐ Ulcers
☐ Drug/Alcohol Abuse	☐ Low Blood Pressure	☐ Venereal Disease
☐ Emphysema	☐ Mitral Valve Prolapse	☐ Pre-Medication for dental Treatment

Has the minor been hospitalized? _____ Reason: _____

Is there any other medical history or problem you feel should be brought to the doctor's attention? ☐ Yes ☐ No

What? _____

Are you allergic to any of the following:

☐ Aspirin	☐ Erythromycin	☐ Tetracycline
☐ Codeine	☐ Latex	☐ Bleach
☐ Dental Anesthetics	☐ Penicillin	

Please list any other drugs the child may be allergic to: _____

Dental History: Is the child in pain currently? _____ How long? _____

Are the child's teeth sensitive to: Cold _____ Heat _____ Biting _____

Has the child had pain or discomfort in the jaw joint (TMJ/TMD)? _____

Has the child had any swelling? _____ Gums Bleeding? _____

I understand that the above information is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Honolulu Endodontics, Inc. of any changes in my medical status. I authorize release of medical information if necessary.

Signature _____ Relationship to child: _____

Date: _____