Pyfferoen Pediatric Dentistry

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CHILD'S REGISTRATION

PLEASE PRINT

Today's Date

Child's Information

Child's Last Name	First Name	MI	Preferred Name	Social Security #

Gender ☐Male ☐Female	Date of Birth	Current Age	Grade	School

Child's Address	City	State	Zip	Home Telephone

Email Address For Family

Parent's Information

Mother's Name	Circle One Mother/Stepmother/Guardian	Date of Birth	Social Security #

Address	City	State	Zip	Driver's License Number	Home Phone

Employer	Work Phone	Cell Phone	Preferred Number: (circle) Home Work Cell

Father's Name	Circle One Father/Stepfather/Guardian	Date of Birth	Social Security #

Address	City	State	Zip	Driver's License Number	Home Phone

Employer	Work Phone	Cell Phone	Preferred Number: (circle) Home Work Cell

Who is the responsible party? Name: _____ **Relationship:**_____

Who is accompanying the child today? Name: _____**Relationship:**_____

Name of person with legal custody of the child? _____

How did you hear about us? Friend Family Internet Phone Book Referring Dr:_____**Other:**_____

Names and ages of other children in the family: _____

Emergency Contact (Other Than Parents)

Last Name, First Name, MI	Relationship	Home Phone:	Other Phone:

DENTAL INSURANCE INFORMATION

Primary Insurance Co. Name		Secondary Insurance Co. Name

Name of Policy Holder		Name of Policy Holder

Policy Number /Social Security Number	Group Number		Policy Number /Social Security Number	Group Number

Policy Holder's Employer	Policy Holder's Birth Date		Policy Holder's Employer	Policy Holder's Birth Date

CHILD'S HEALTH HISTORY

Child's Name:	Date:

CHILD'S MEDICAL DOCTOR/PHYSICIAN		
Name	**Phone**	**Fax**
Address	**Date of Last Visit**	**Reason**

Does your child have any ALLERGIES to any foods/medications/material (ex. Latex)? Yes No If yes, please list and explain the reaction: _____

Is your child currently taking any medications? Yes No If yes, please list: _____

_____

Does your child require antibiotics for dental work? Yes No If yes, please explain: _____

HAVE YOUR CHILD EVER BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING PROBLEMS?	NO	YES (If Yes, Please Explain)
Abnormal Bleeding		
Anemia (List type_____)		
Asthma		
Autism		
Birth Defects		
Bone/Joint Problems		
Blood Transfusion		
Cancer/Tumors		
Chemotherapy/Radiation		
Cerebral Palsy		
Cleft Lip/Cleft Palate		
Congenital Heart Disease		
Convulsions/Epilepsy		
Development Delay		
Diabetes		
Down Syndrome		
Hearing/Speech Impairment		
Heart Murmur/Defect		
Heart Surgery		
Hemophilia		
Hepatitis		
HIV+/AIDS		
High Blood Pressure		
Hospitalizations (Overnight stays)		
Hyperactivitity-ADHD/ADD/ODD		
Kidney/Liver Problems		
Mental Illness/Psychiatric Care		
Seizures/Convulsions/Epilepsy		
Surgeries/Operations		
Syndrome (Please List)_____		

Any other disease, illness, past surgeries, or health concerns not listed above? _____

_____

_____

CHILD'S DENTAL HEALTH

	Child's Name:	Date:
REASON FOR SEEKING TREATMENT?		

DENTAL HISTORY

Is this your child's first dental visit? Yes No If no, who was their previous dentist?_____

How long since the last dental visit? _____

Were any x-rays taken at previous dental visits? _____

Has your child ever received injuries to the teeth, face, or mouth? If yes, please explain. _____

_____

Does your child have a history of a thumb, finger, or pacifier habit? _____

Does your child have a history of breast feeding? Yes No If yes, how long _____ or bottle feeding? Yes No If yes, how long _____

Has your child ever had an unpleasant dental experience? If yes, please explain. _____

Has your child had any recent dental pain? Yes No, If yes, please explain_____

HOME DENTAL CARE

How often does your child do the following? brush_____ (times per day) and floss _____(times per week)

What kind of toothpaste is used?_____

Does your child receive help brushing and flossing? Yes No If yes, who is the primary helper?_____

Does your child drink well water, bottled water or city water? _____

DIET

Was/is your child put to bed with a bottle? Yes No If yes, what was/is in the bottle? _____

Was/is your child allowed to carry a bottle or cup throughout the day containing something other than plain water? Yes No

How many meals per day does your child eat? _____ **How many snacks does your child have per day?** _____

Please list some favorite/frequent snacks: _____ **and drinks:** _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize Dr. Pyfferoen and his staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Pyfferoen to diagnose and/or treat my child's dental problems. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes.

_____ _____

Signature of Parent or Guardian Date