MINOR REGISTRATION FORM (Age 16 yrs. and younger)

If unable to keep your appointment, please give a 24 hour notice to avoid a missed appointment fee.

GENERAL INFORMATION: Date _____

Full name of child _____ Preferred name _____

Date of birth of child _____ Sex _____ School and grade _____

Mother's name _____ Father's name _____

Home phone # _____ Child's cell # _____

Mother's cell # _____ Mother's email _____

Father's cell # _____ Father's email _____

Mailing address _____

street # city state zip

Father's work # _____ Father's occupation & employer _____

Mother's work # _____ Mother's occupation & employer _____

Parent's marital status (circle) single married widowed separated divorced

Person responsible for payment of account _____

Do you have dental insurance? ☐ yes ☐ no If yes, name of insurance co. _____

Policy holder _____ Subscriber ID/Social Security number _____

Group insurance number _____

Whom may we thank for referring you to our office? _____

MEDICAL HISTORY:

1. Please state name and address of child's physician _____

2. Is your child currently being treated by his or her physician? _____ For what? _____

3. Is your child currently taking any prescription or over-the-counter medication? _____ If yes please list below:

Medication	Condition	Medication	Condition

4. Has your child ever been hospitalized? _____ For what? _____ Date _____

5. Has your child had any history of the following? (If yes, circle)

Heart Trouble	Glandular Problems	Unconsciousness	Brain Injury	Diabetes
Lung Problems	Convulsions	Temper Tantrums	Seizures	Kidney Involvement
Liver Involvement	Asthma	Bleeding Disorders	Allergies	Circulatory Problems

OTHER (Specify) _____

Comments: _____

_____

6. Is your child allergic to anything? (i.e. Foods, Medication, Penicillin, Anesthetic) _____

7. Has your child had any hearing, sight, coordination, or special school problems? _____

8. May we use nitrous oxide (gas) on your child? _____

Dental History:

The main purpose for your visit is: Complete Dental Evaluation

Because of a Toothache

Because of Crooked Teeth

Other (specify) _____

Is this your child's first visit to any dentist? _____

Has your child had any unfavorable medical or dental experience? _____

Please explain _____

	YES	NO
Have you had instruction on proper home care techniques, including the use of dental floss?	☐	☐
Do you have fluoridated water in your home?	☐	☐
Is your child on a diet for any reason?	☐	☐
If yes, for what reasons? _____		
Have there been any injuries to the teeth such as falls, chips, blows, etc.?	☐	☐
Are there any oral habits? Finger or thumb-sucking?	☐	☐

Thank you for your time in filling out these important questions. They will help us understand your child more completely and develop a complete treatment plan.

The above information I have provided is correct and it is my responsibility to inform this office of any changes in my child's medical status. I have had full opportunity to read and consider your Notice of Privacy Practices. I understand that I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations. My signature authorizes release of information to process my child's claim and to other health care providers about my child's history, examination, diagnosis, and treatment course. In addition, I agree CDDG, its' affiliates and agents may use an automated telephone dialing system and/or pre-recorded messages to contact the wireless number(s) and/or residential lines that I provide to CDDG for appointment and payment purposes. Balances of 60 days and over are subject to 1.5% finance charge.

Regular dental cleanings and check-ups are essential for maintenance of dental health and prevention of disease. Commerce Drive Dental provides routine hygiene appointments every six months. These appointments include an exam, cleaning and fluoride. Bitewing x-rays will be taken every twelve months and a panoramic x-ray may be taken every three to five years as recommended by the ADA. I give consent for Commerce Drive Dental to provide this treatment to my child until I provide written notice otherwise. This includes if my child comes alone or with another adult.

Signature _____

Relationship to the patient _____

Date _____

MEDICAL HEALTH UPDATE

Date	Change	Parent Initial	Staff Initial	Accompanied By (Relationship to Patient)
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____
_____	Y / N	_____	_____	_____