DENTAL REGISTRATION AND HISTORY
(For Child Registration Only)

Watts Family Dental

Date: Home Phone ( ) Cell Phone ( )

CHILD/MINOR PATIENT INFORMATION

Welcome to Watts Family Dental!

We are pleased to welcome you, your child and your whole family to the Watts Family Dental practice. Please take a few moments to fill out this form as completely as you can; there are 2 pages total. If you have questions, we will be glad to help you! We look forward to working with you to maintain your child's dental health.

Last Name First Name Middle Initial

Address:

City: State: Zip:

Sex ☐ M ☐ F Age: Birthdate: Nickname:

Hobbies

Person Financially Responsible Home Phone ( )

Relationship Work Phone ( )

Whom may we thank for referring you?

In case of emergency, who should be notified? Phone ( )

INSURANCE INFORMATION

Father's/Guardian Name	Mother's/Guardian Name
Address (if different from patient's)	Address (if different from patient's)
Home Phone ( )	Home Phone ( )
Work Phone ( )	Work Phone ( )
Employer	Employer
SSN Birthdate	SSN Birthdate
Do you have dental insurance coverage for this minor/child?	Do you have dental insurance coverage for this minor/child?
☐ Yes ☐ No	☐ Yes ☐ No
Plan Name	Plan Name
Phone Number	Phone Number
Address	Address
Group #	Group #
Policy #	Policy #
Is your child eligible for treatment under Medical Assistance?	Is your child eligible for treatment under Medical Assistance?
☐ Yes ☐ No	☐ Yes ☐ No
If yes, Medical Assistance ID #	If yes, Medical Assistance ID #

CHILD'S DENTAL HISTORY

Reason for Today's Visit Date of last dental care

Former Dentist Date of last dental X-rays

Answer the following about your minor/child. Has your child, or does your child…

- ☐ Have general dental complaints?
- ☐ Brush daily?
- ☐ Floss daily?
- ☐ Take flouride?
- ☐ Have mouth injuries?
- ☐ Have previous unhappy dental care or dental
- ☐ Have any of the following oral habits or conditions? thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc.?

Watts Family Dental

DENTAL HEALTH HISTORY
(For Child Registration Only)

CHILD'S MEDICAL HISTORY

Physician's Name

Date of Last Examination

City State Zip

Results

Is your child under the care of a Physician now? ☐ Yes ☐ No

Medications

Receiving any medications or drugs? ☐ Yes ☐ No

Ever been hospitalized? ☐ Yes ☐ No

Ever had surgery? ☐ Yes ☐ No

Allergies

Is there excessive bledding when cut? ☐ Yes ☐ No

Check if you have had problems with any of the following

☐ AIDS/HIV	☐ Chicken Pox	☐ Hearing Problems	☐ Mononucleosis
☐ Anemia	☐ Convulsions	☐ Heart Problems	☐ Mumps
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever
☐ Bladder Problems	☐ Drug/Alcohol Abuse	☐ Kidney Disease	☐ Sinus Problems
☐ Cancer	☐ Epilepsy	☐ Liver Disease	☐ Thyroid Disease
☐ Cerebal Palsy	☐ Fainting	☐ Measles	☐ Tuberculosis

☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name Relationship Phone

AUTHORIZATIONS

The information I have given is correct to the best of my knowledge. I understand 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 authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian Date

I certify that my minor/child is covered by insurance with:

I assign direct to Dr. Watts all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian Date

UPDATES

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe

Is patient taking any new medications? ☐ Yes ☐ No

Medications