FAMILY AND IMPLANT DENTISTRY

CHILD REGISTRATION----------

Child's name_____Date_____

Birthday_____Age_____

Parent's Information:

Father_____SSN_____DOB_____

Address_____

Home phone_____Work phone_____

Employer_____E-mail address_____

Mother_____ SSN _____DOB_____

Address_____

Home phone_____Work phone_____

Employer_____E-mail address_____

Insurance Information:

Primary Policyholder_____DOB_____

Name and address of Insurance Company_____

_____

ID number_____Group number_____

Secondary Policyholder (if applicable)_____DOB_____

Name and address of Insurance Company_____

_____

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FAMILY AND IMPLANT DENTISTRY

ID number_____Group number_____

Date of last dental cleaning and exam_____

Date of last medical exam_____

Medical History:

Anemia	Yes	No
Diabetes	Yes	No
Hepatitis	Yes	No
Asthma	Yes	No
Allergies		
To Penicillin	Yes	No
To local anesthetic	Yes	No
Abnormal heart condition	Yes	No
Abnormal bleeding from a cut	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No

Has your child ever been told they need to be premedicated with an antibiotic before dental cleanings or treatment _____

Is your child under the care of a physician now _____

Is any medication being taken at this time _____

Other physical conditions _____

Name of physician_____

Telephone number_____

Whom may we thank for referring you_____

Information given by (signature)_____