141 Captain Thomas Boulevard
West Haven, CT 06516
Tel: (203)932-3675 – Fax: (203)934-9701

Child Registration

ABOUT YOUR CHILD

Full Legal Name: Last	First	Middle	
☐ Female ☐ Male	Date of Birth (Month/Day/Year):	Child's Preferred Name:	
Mailing Address:			
City:	State:	Zip Code:	School:
Home Phone Number ( ) -			Grade Level:
Name of child's pet	Child's Favorite Sports or Activities/Interests		

FAMILY INFORMATION

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single

Mother's Full Name:	Father's Full Name:
Home Address if different than child:	Home Address if different than child:
City, State, Zip Code:	City, State, Zip Code:
Cell Phone Number:	Cell Phone Number:
Date of Birth:	Date of Birth:
Occupation/Employer:	Occupation/Employer:

Child Lives With: ❑ Both parents ❑Mother ❑Father ❑Other _____

Who is responsible for making appointments?

What is the best number to reach you? What is the best time to call?

Who is responsible for financial arrangements and payments?

INSURANCE INFORMATION

Insurance Company Name

Policy Holder:	Date of Birth:	Subscriber #	Group #

REFERRAL INFORMATION

How did you hear about our office?

☐ Family/Friend _____ ☐ Referring Doctor _____

☐ Insurance Company ☐ Internet

I hereby certify that the above information is true and correct. I understand it is my responsibility to notify the office of any changes.

Signature Of Parent/Legal Guardian: _____ Date: _____

West Shore FAMILY DENTAL

Today's Date: _____

Child's Name: _____

DENTAL HISTORY

Reason for today's visit? _____ Is your child in any pain? ❑ Yes ❑ No ❑ Don't Know

Is this your child's first visit to the dentist? ❑ Yes ❑ No

If no, when was the last visit and what was done for your child? _____

Name of Previous Dentist: _____

Do you expect your child to be a cooperative patient? ❑ Yes ❑ No If no, please explain: _____

Is your home water supply fluoridated? ❑ Yes ❑ No ❑ Don't Know

Does your child take fluoride tablets or vitamins with fluoride? ❑ Yes ❑ No

Has your child bumped any teeth or had any injuries to the teeth, head, jaws or neck? ❑ Yes ❑ No

If so, when? _____

Has your child had a history of headaches, pain, popping or clicking of the jaws? ❑ Yes ❑ No ❑ Don't Know

Is/was your child bottle fed? ❑ Yes ❑ No If yes, until what age? _____

Is/was your child breast fed? ❑ Yes ❑ No If yes, until what age? _____

Does your child have a night time bottle? ❑ Yes ❑ No ❑ Don't Know

Does your child have or has he or she had any of the following problems or habits?

❑ Thumb Sucking How Long?_____ Still Active ❑ Yes ❑ No

❑ Finger Habit How Long?_____ Still Active ❑ Yes ❑ No

❑ Pacifier How Long?_____ Still Active ❑ Yes ❑ No

❑Tongue thrusting ❑Nail Biting ❑Pacifier ❑Teeth grinding ❑Mouth breathing ❑Lip Licking ❑Sippy Cup

How often does your child brush?_____ Is toothbrushing supervised? ❑ Yes ❑ No

By whom?_____ Is dental floss used? ❑ Yes ❑ No

Does your child drink bottled water? ❑ Yes ❑ No If yes, how often? _____

MEDICAL HISTORY

Is your child presently under the care of your family physician for any medical reason? ❑ Yes ❑ No

If yes, explain _____ _____

Physician's Name:_____ Phone Number: _____

Address: _____

• Is your child in good health? ❑ Yes ❑ No If no, explain _____

• Does your child have any drug allergies? ❑ Yes ❑ No If yes, explain _____

Does your child have any food allergies? ❑ Yes ❑ No If yes, explain _____

• Is your child taking any medications at this time? ❑ Yes ❑ No

If yes, list. _____ _____

• Has your child ever been hospitalized or treated in an emergency room for any particular trauma? ❑ Yes ❑ No

If yes, when and for what reason? _____ _____

• Does your child have, or has he or she had, any emotional, mental or nervous disorders? ❑ Yes ❑ No

If yes, please explain. _____ _____

• Have your child's tonsils and/or adenoids been removed? ❑ Yes ❑ No

• Does your child breathe through the mouth? ❑ Yes ❑ No If yes, ❑ Seldom ❑ Often

Has your child been diagnosed with any of the following conditions?		
❑ Yes ❑ No ADD/ADHD	❑ Yes ❑ No Convulsions/Seizures	❑ Yes ❑ No Nutritional Deficiency
❑ Yes ❑ No Anemia	❑ Yes ❑ No Diabetes	❑ Yes ❑ No Oral ulcers
❑ Yes ❑ No Asthma	❑ Yes ❑ No Emotional Disturbance	❑ Yes ❑ No Orthopedic problems
❑ Yes ❑ No Autism	❑ Yes ❑ No Epilepsy	❑ Yes ❑ No Premature birth
❑ Yes ❑ No Bladder conditions	❑ Yes ❑ No Excessive gagging	❑ Yes ❑ No Psychiatric disorder
❑ Yes ❑ No Bleeding problems	❑ Yes ❑ No Fainting/dizziness	❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Birth defects	❑ Yes ❑ No Gastrointestinal problems	❑ Yes ❑ No Sensory issues
❑ Yes ❑ No Bone or joint problems	❑ Yes ❑ No Growth/ Developmental Issues	❑ Yes ❑ No Sickle Cell Anemia
❑ Yes ❑ No Brain/spinal injury	❑ Yes ❑ No Hearing loss/deafness	❑ Yes ❑ No Speech Disorder
❑ Yes ❑ No Bruising problems	❑ Yes ❑ No Heart murmur	❑ Yes ❑ No Steroid Therapy
❑ Yes ❑ No Cancer of malignancies	❑ Yes ❑ No Hepatitis	❑ Yes ❑ No Thyroid problems
❑ Yes ❑ No Cerebral Palsy	❑ Yes ❑ No Kidney disease	❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Chronic tonsil/adenoid infections	❑ Yes ❑ No Learning disability	❑ Yes ❑ No Vision Problems
	❑ Yes ❑ No Leukemia	❑ Yes ❑ No Other _____
❑ Yes ❑ No Chronic ear infections	❑ Yes ❑ No Liver disease	
❑ Yes ❑ No Cleft lip/palate	❑ Yes ❑ No Mental disability	
❑ Yes ❑ No Congenital Heart Disease		

Please describe any current medical treatment including medications, pending surgeries, recent injuries or other information we should be aware of that has not been covered: _____

Preferred Pharmacy: _____City:_____ State:_____ Phone:_____

EMERGENCY CONTACT (Other than Parent)		
Emergency Contact: Last	First	Middle
Relationship	Home Phone Number ( ) -	Other Phone Number ( ) -

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform West Shore Family Dental of any changes in my child's medical status.

Signature of Parent or Guardian: _____ Date: _____

PATIENT CONSENT (MINOR)

Clinical

1. As the parent/legal guardian of _____ ("Patient"), I authorize West Shore Family Dental to perform all recommended treatment on the Patient.

2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payers and/or other health professionals.

3. I authorize the use of anesthetics, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on behalf of the Patient. I understand that payment is due when services are rendered. Should my account become delinquent, I will be responsible for all additional collection costs including reasonable attorney fees.

5. A $75 Missed Appointment Fee will be charged to my account for all missed appointments by Patient. I am aware that the practice requests a notice of at least 2 working days for any cancellation or change of appointment

Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the Patient's medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment for services rendered or preauthorizations necessary to my insurance company, on my behalf or on Patient's behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of the coverage provided.

I have read this Patient Consent and agree to the terms and conditions herein.

Print Name of Patient _____ Date of Birth _____

Print Name of Parent or Guardian _____

Signature of Parent or Guardian _____ Date _____