CHILD/MINOR REGISTRATION FORM

Section I **Patient Information** **Date**________________________

Child's Full Name____________________________________ Nickname_____________Date of Birth____/____/_____Sex ☐ M ☐ F

Parent/Guardian information

Parent/Guardian's Name____ Relationship to patient__________________________
Address____City__________________________State_________Zip______________
Cell Phone (______)____________________________Textable? ☐ Yes ☐ No Other phone(______)__________________________
Email Address____ Can we send you appointment emails? ☐ Yes ☐ No

Whom may we thank for referring you? ____
Person to contact in case of emergency____ Phone_____________________________

Section II **Insurance Information**

Primary Insurance

Name of Insured____________________________________
DOB____
SSN#:____
Relationship to Patient _______________________________
Name of Employer___________________________________
Insurance Company__________________________________
Group #____
ID#____

Secondary Insurance (If applicable)

Name of Insured____________________________________
DOB____
SSN#:____
Relationship to Patient _______________________________
Name of Employer___________________________________
Insurance Company__________________________________
Group #____
ID#____

Section III **Financial Information and Assignment of Benefits Authorization**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. If my dental insurance company does not remit payment within 60 days, the balance of my account will be due in full from me and I will be asked to follow up with my insurance company. I understand that my secondary insurance cannot be billed until a primary insurance explanation of benefits is received by this office. I understand that I am responsible for all costs of dental treatment and have had the opportunity to discuss the financial policy of this office.

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

I hereby assign all rights and benefits under my dental insurance contract to Greenview Dental Care for the purpose of determining the details of the benefits of this policy and obtaining payment for services given. This assignment further permits Greenview Dental Care to obtain all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Greenview Dental Care of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered. This assignment shall allow Greenview Dental Care to take all action necessary to obtain the benefits I have, in good faith. All benefits are to be paid directly to Greenview Dental Care. If my current policy prohibits direct payment to Dr, then I hereby also instruct and direct you to make out the check to me and mail it care of the Doctor. A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize Greenview Dental Care to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf. This assignment shall remain in effect for the duration of treatment and any additional time necessary to secure full payment for services rendered. This is a direct assignment of my rights and benefits under this policy.

X____ **Date** ____________________________

Parent's/Guardian's Signature

(over)

CONFIDENTIAL HEALTH HISTORY FOR CHILD/MINOR

Child's Dental History

What is the *primary* reason for today's dental appointment? ☐ Examination ☐ Emergency ☐ Consultation

(*please circle*)

Does the child have a specific dental problem? Describe ______________________________ Yes No
Is this the child's first visit to a dentist? Date of last visit ______________________________ Yes No
Has the child had problems with prior dental treatments? ______________________________ Yes No
Has the child ever suffered any injuries to the mouth, head or teeth? Describe______________________________ Yes No
Has the child had any problems with eruption or shedding of teeth? ______________________________ Yes No
Has the child had any orthodontic treatment? ______________________________ Yes No

Is the child's home water supply fluoridated? ______________________________ Yes No
Does the child take fluoride supplements? ______________________________ Yes No
Does the child use fluoride toothpaste? ______________________________ Yes No

Does the child suck his/her thumb, fingers, or pacifier? ______________________________ Yes No
Does the child participate in any active recreational activities? ______________________________ Yes No

How many times are the child's teeth brushed per day? ____________ When?____________Floss?____________
At what age did the child STOP bottle feeding? Age____________Breastfeeding? Until Age____________

Child's Medical History

Child's Physician ____________Phone____________Date of Last Visit____________

Is the child's general health good? If no, explain ______________________________ Yes No
Has there been a change in your health within the last year? If yes, explain ______________________________ Yes No
Has the child ever been hospitalized or had a major operation? If yes, explain ______________________________ Yes No
Is the child currently under the care of a physician? If yes, explain ______________________________ Yes No
Is the child currently taking any medications? Please list ______________________________ Yes No
____

Is the child allergic to any of the following: ☐ Latex ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Local anesthetic ☐ Metal ☐ Food
Please list any other allergies______________________________

Has the child had any history of, or conditions related to, any of the following? Please circle YES or NO for each.

Anemia	yes/no	Chicken Pox	yes/no	Hepatitis	yes/no	Pregnancy (teen)	yes/no
Arthritis	yes/no	Chronic Sinusitis	yes/no	HIV+/AIDS	yes/no	Rheumatic Fever	yes/no
Asthma	yes/no	Diabetes	yes/no	Immunizations	yes/no	Seizures	yes/no
Bladder	yes/no	Earaches	yes/no	Kidney	yes/no	Sickle Cell	yes/no
Bleeding Disorders	yes/no	Epilepsy	yes/no	Liver	yes/no	Thyroid	yes/no
Bones/Joints	yes/no	Fainting	yes/no	Measles	yes/no	Tobacco/Drug use	yes/no
Cancer	yes/no	Growth Problems	yes/no	Mononucleosis	yes/no	Tuberculosis	yes/no
Cerebral Palsy	yes/no	Heart	yes/no	Mumps	yes/no	Venereal Disease	yes/no

Has the child been diagnosed with other diseases or medical problems NOT listed on this form?____________ yes/no
Has the child ever been pre-medicated for dental treatment? If YES, when____________ yes/no
Are immunizations current?______________________________ yes/no
Is there any issue or condition that you would like to discuss with the dentist in private? ____________ **yes/no**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the dentist and staff at the next appointment without fail.

Parent's/Guardian's Signature ______________________________ **Date** ____________
Relationship to Child______________________________

Dentist's Signature and Date