STEVEN M. HALL DDS **AARON S. CLARK DDS**

CHILDREN'S REGISTRATION FORM

CHILD'S NAME_____________________________ NICKNAME____________________________ DATE OF BIRTH___________ AGE____

SCHOOL ATTENDING_________________________________ CHILD'S PHYSICIAN____

HABITS WE SHOULD BE AWARE OF ____

HAS CHILD BEEN TO THE DENTIST BEFORE_________________________________ LAST DENTAL X-RAYS_________________________

YES NO

☐ ☐ IS CHILD ALLERGIC OR SENSITIVE TO ANYTHING? IF SO, WHAT?____

☐ ☐ IS CHILD CURRENTLY ON MEDICATION? IF SO, WHAT?____

____

☐ ☐ HAS CHILD HAD ANY UNFAVORABLE REACTIONS TO DENTAL OR MEDICAL TREATMENT?______________________________

☐ ☐ IS CHILD'S WATER SUPPLY FLUORIDATED (CITY OR WELL WATER)?____

☐ ☐ WOULD YOU LIKE CHILD TO HAVE FLUORIDE TREATMENTS WITH CLEANING?_____________________________________

DOES CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING:

HEART TROUBLE	RHEUMATIC FEVER	EPILEPSY	DEABETES	NERVOUSNESS
EASY BLEEDING	MENTAL DISORDERS	ASTHMA	HYPERACTIVITY	MAJOR SURGERY

PERSON RESPONSIBLE FOR CHILD'S ACCOUNT

NAME_____________________________________ HOME PHONE_________________________ CELL___________________________

EMAIL_____________________________________ ☐ SINGLE ☐ MARRIED ☐ DIVORDED ☐ WIDOW ☐ WIDOWER

HOME ADDRESS____ CITY____________________ STATE____ ZIP______________

WORK ADDRESS____ CITY____________________STATE____ZIP_______________

WORK PHONE____

INSURANCE____

REFERRED BY____

SOCIAL SECURITY #_________________________ SIGNATURE_______________________________________ DATE_______________

ADULT REGISTRATION FORM NEEDED AT AGE 14

Medical History Update

PLEASE REVIEW YOUR REGISTRATION AND HEALTH HISTORY FORM AND EXPLAIN ANY CHANGES.

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SIGNATURE____DATE_____________

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