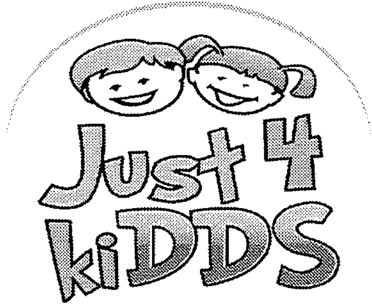


Dentistry For Children
Jordan E. Higham DDS

Patient Name: ______________________

Patient DOB: ______________________

Confidential Patient Registration

Who Is Accompanying the Child Today?

Name ______________ Relationship ______________

Do you have legal custody of the child? YES___NO____

Guardian's Email Address (used for appointment reminders and electronic statements only)

____

Insurance Information

Dental Insurance Company ______________________

Policy Holder ______________________

Subscriber ID # ______________________

Parent Information

Mother's Name ______________ Birth Date ______________

Address City ST Zip

Employer ______________ Social Security # ______________

Home Phone # ______________ Cell Phone # ______________

Father's Name ______________ Birth Date ______________

Address, if different City ST Zip

Employer ______________ Social Security # ______________

Home Phone # ______________ Cell Phone # ______________

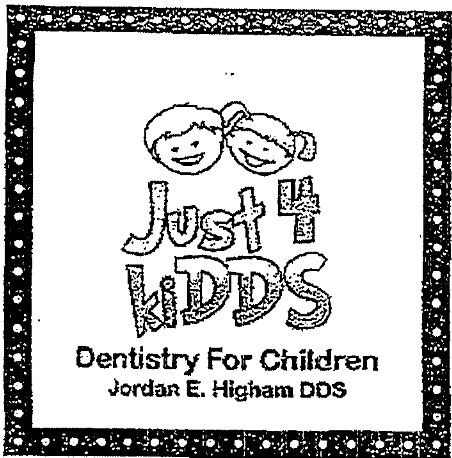
Emergency Contact Information

Please list someone, other than the parent, to contact in case of an emergency

Name ______________ #Phone ______________

How did you hear about our office?

____



Health Care Provider

____
Child's Physician/Pediatrician

____
Phone # City State Zip

****

Dental History

- What is the reason for your child's dental visit?
____
- Has your child ever been to the dentist? ____________
- Name of Previous Dentist ____________
- Date of last cleaning____________ X-rays____________
- Has your child had any previous unpleasant experiences with dental care?____________
Explain:____________
____
- Does your child suck a finger or pacifier?____________
- Does your child go to sleep with a bottle or sippy cup?
____
- Has your child been sedated for dental treatment?
____
- Were there any problems? ____________
- Have your child's teeth ever been injured? ____________
Which teeth?____________
- Dental treatment received for trauma?____________
- Please check box if your child is having problems with any of the following:

☐ Cavities
☐ Gum Infection
☐ Trauma
☐ Teeth Grinding
☐ Toothache
☐ Tooth Color
☐ Sensitive Teeth
☐ Orthodontics
☐ Mouth Breathing
☐ Jaw Sounds
☐ Other____________

Comments:____________
____
____

Patient Name:

____

Birth Date ______ Age ______ Boy ______ Girl ______

Medical History

- Is your child in good health?____________
- Date of last physical exam?____________
- Has your child ever had a health problem?____________
- Has your child ever been hospitalized, had general anesthesia, or emergency room visits?____________
Explain:____________
____
- Is your child allergic to anything?____________
____
- Is your child currently taking any medications?____________
Please list medication, dose, and reason:____________
____
- Are your child's immunizations current?____________
- Have you ever been told that your child needs to take antibiotic before dental treatment?____________
- Were there any difficulties at birth?____________
____
- Do you consider your child to be:

☐ Advanced in the learning process
☐ Progressing normally
☐ Slow in the learning process

- Please check box if your child has been treated for any of the following:

☐ Autism
☐ Diabetes
☐ Asthma
☐ Snoring
☐ Seizures
☐ Heart Condition
☐ Hepatitis/Liver Disease
☐ Mental Delays
☐ Cancer/Tumors
☐ Tonsil/Adenoid Problems
☐ Cleft Lip/Palate
☐ Sickle Cell Disease/Trait
☐ Prolonged Bleeding
☐ Emotional Disorders
☐ Speech/Hearing Problems
☐ Kidney Disease
☐ Tuberculosis
☐ AIDS
☐ Other____________

Please further describe any checked boxes: ____________
____
____
____