

# Scott A. Simpson, DDS, PLLC

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## Child's Registration and Medical History

Your child's complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

### 1 ABOUT CHILD

Today's Date: \_\_\_\_\_

**Name:** \_\_\_\_\_

Nickname: \_\_\_\_\_ LAST FIRST MI  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_ APT / CONDO #

\_\_\_\_\_ CITY STATE ZIP

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Where and when are best times to reach you? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

### 2 PARENT INFORMATION

Father's Name: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ DL #: \_\_\_\_\_

#### Person Responsible for Account:

Work #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

### 3 DENTAL INSURANCE

#### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### In the event of an emergency, who should be notified, other than a parent?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Work #: (\_\_\_\_) \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

### 4 MEDICAL HISTORY

Does your child have a personal physician?.....  Yes  No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is the child currently under the care of a physician?.....  Yes  No

Please Explain: \_\_\_\_\_

CONTINUED ON BACK

## 4 MEDICAL HISTORY *continued*

Date of last physical: \_\_\_\_\_

Child's current physical health is:.....  Good  Fair  Poor

Is child taking any prescription, over-the-counter, or supplement drugs?  
 Yes  No

Please list each one: \_\_\_\_\_  
\_\_\_\_\_

Does your child smoke or use tobacco in any other form?..... Yes  No

### Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Aids or Other                     | <input type="checkbox"/> Epilepsy                              |
| <input type="checkbox"/> Immunosuppressive Disorders       | <input type="checkbox"/> Hearing Problems                      |
| <input type="checkbox"/> Allergies to Anesthetics          | <input type="checkbox"/> Heart Problems                        |
| <input type="checkbox"/> Allergies to Medicines or Drugs   | <input type="checkbox"/> Hemophilia                            |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Kidney Problems                       |
| <input type="checkbox"/> Bladder Problems                  | <input type="checkbox"/> Mononucleosis                         |
| <input type="checkbox"/> Cerebral Palsy                    | <input type="checkbox"/> Radiation Treatment                   |
| <input type="checkbox"/> Chemical Dependency               | <input type="checkbox"/> Rheumatic Fever                       |
| <input type="checkbox"/> Convulsions                       | <input type="checkbox"/> Thyroid Problems                      |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Tuberculosis                          |

Please list any serious medical condition(s) that your child has had:  
\_\_\_\_\_  
\_\_\_\_\_

### Is your child allergic to any of the following?

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Erythromycin   | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Jewelry/Metals | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex          | <input type="checkbox"/> Other        |

Please list any other drugs/materials that child is allergic to: \_\_\_\_\_  
\_\_\_\_\_

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

## 5 DENTAL HISTORY

### Why have you come to the dentist today?

\_\_\_\_\_  
\_\_\_\_\_

When was child's last dental visit? \_\_\_\_\_

Experiencing any discomfort now? \_\_\_\_\_

Do you desire complete dental service for your child? \_\_\_\_\_

Has your child ever responded adversely to medical or dental treatment?  
\_\_\_\_\_

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work?..... Yes  No

Is there anything else we should know about child's dental history? \_\_\_\_\_  
\_\_\_\_\_

How many times a week does child floss? \_\_\_\_\_

How many times a day does child brush? \_\_\_\_\_

Type of bristles?  Hard  Medium  Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to child

Payment is due in full at the time of treatment unless prior arrangements have been approved.

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_  
\_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

2. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_

3. Date: \_\_\_\_\_ Comments: \_\_\_\_\_ Signature: \_\_\_\_\_