TOP SECRET

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PATIENT'S REGISTRATION AND HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

CHILD'S NAME: _____

Today's Date _____

Address _____

City _____ Zip _____

Home Phone # _____

Birthdate _____ Age _____ Gender _____

School _____

Parent/Guardian Full Name _____

Email Address _____

Home Phone # _____

Cell Phone # _____

If your child's name and address are not the same as yours, please complete the following information:

Address _____

_____

DENTAL INSURANCE

Primary Carrier

Insurance Co. _____

Employee _____

Employer _____

SS# _____

Employee DOB _____

Group # _____

Date Employed _____

Secondary Carrier

Insurance Co. _____

Employee _____

Employer _____

SS# _____

Employee DOB _____

Group # _____

Date Employed _____

If applicable, which insurance is primary by legal documentation? _____

Marital Status:

___Married ___Single ___Divorced ___Widowed

ACCOUNT INFORMATION

Person responsible for account

Social Security # _____

Date of Birth _____

DL#/State ID _____

YOUR:

Name _____

Occupation _____

Employer _____

Work Address _____

Work Telephone _____

YOUR SPOUSE:

Name _____

Occupation _____

Employer _____

Work Address _____

Work Telephone _____

GETTING TO KNOW YOU

Child's Physician _____

Family Dentist _____

Is another member of your family, or relative a patient at our office?

YES / NO Who? _____

How did you hear about KidZaam?

_____

Emergency Contact _____

Phone Number _____

Address _____

Closest relative not living with you

_____

Phone Number _____

Address _____

OFFICIAL DOCUMENT KDA KAVITY DETECTION AGENCY

OVER

REASON FOR BRINGING CHILD TO THE DENTIST _____

HISTORY

	YES	NO
1. Is your child being treated by a physician at this time?	☐	☐
2. Are all immunizations current?	☐	☐
3. Has your child ever been a patient in a hospital?	☐	☐
4. Has your child ever received general anesthesia?	☐	☐
5. Is your child allergic to anything: (medicine, food)? If so what? _____	☐	☐
6. Is your child taking any medications at this time? If yes, what? _____	☐	☐
7. Has your child ever been seen by a dentist before?	☐	☐
8. Has your child ever received fluoride in any form? If yes, what? _____	☐	☐
9. Does your child suck his/her thumb, fingers, pacifier?	☐	☐
10. Are your child's teeth brushed once a day? _____ times?	☐	☐
11. What type of toothpaste does your child use? _____		
12. At what age did your child stop bottle/breast feeding? _____		
13. This child is adopted	☐	☐

REVIEWER COMMENTS

_____

_____

_____

_____

_____

RECALL DATES

_____

_____

_____

_____

_____

ORGANS AND SYSTEMS

HAS THIS CHILD EVER HAD TREATMENT FOR ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO

Yes	No		Yes	No		Yes	No	
☐	☐	Blood-Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids
			☐	☐	Lungs			

___ **This child has NOT had treatment for any of the above**

ILLNESS

HAS THIS CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS: PLEASE CHECK YES OR NO:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Epilepsy	☐	☐	Orthopedic Problems
☐	☐	Anemia	☐	☐	Eye Problems	☐	☐	Pneumonia
☐	☐	Allergy	☐	☐	Excessive Bleeding Problem	☐	☐	Polio
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Heart Murmur	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Cancer	☐	☐	Hepatitis - _____	☐	☐	Speech Problems
☐	☐	Cerebral Palsy	☐	☐	Jaundice	☐	☐	Spina Bifida
☐	☐	Chicken Pox	☐	☐	Leukemia	☐	☐	Syndrome _____
☐	☐	Cleft Lip/Palate	☐	☐	Measles	☐	☐	Tetanus
☐	☐	Convulsions/Seizures	☐	☐	Mental Retardation	☐	☐	Whooping Cough
☐	☐	Diabetes	☐	☐	Mumps	☐	☐	Other: _____
☐	☐	Diphtheria	☐	☐	Nutritional Deficiency			
☐	☐	Emotional Disturbance						

☐ **This child has never been diagnosed as having any of the above conditions.**

Is there anything else that you think we should know about your child? _____

_____

_____ _____ _____

Signature of person completing form **Relationship to Patient** **Date**

Initial / Date	Initial / Date	Initial / Date	Initial / Date	Initial / Date	Initial / Date
_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____