Dallas Dental Care
Child Registration Form

Today's Date: _____

Child's Legal Name _____ Name to be called: _____
(Last) (First) (Middle)

Child's Home Phone_____ Age_____ Sex M F

Child's SSN_____ Child' DOB _____

Home Address_____
(Street) (City) (State) (Zip)

Billing Address_____
(Street) (City) (State) (Zip)

County of Residence_____ Does your home have its own well for water? Yes No

For young children: Best Friend's Name_____ Pet's Name_____

Favorite Activities _____

Names and ages of brothers and sisters: _____

Parents/Guardian's Names_____

X Person Financially Responsible_____

Father/Guardian	**Mother/Guardian**
Name:_____	Name_____
Phone _____ Cell _____	Phone _____ Cell _____
Wk #_____	Wk #_____
Date of Birth_____ SSN_____	Date of Birth_____ SSN_____
Address _____	Address _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Dental Ins Co _____	Dental Ins Co _____
Policy # _____	Policy # _____

Whom may we thank for referring you to our practice?_____

Dallas Dental Care
Child Medical Information

Child's Name _____

Are you allergic to Penicillin _____ Are you allergic to any other medications? Y N

If yes, which ones? _____

Are you taking medication? _____List medications you are taking and reasons why:

_____

Have you ever been told by a physician to take antibiotics before dental treatment? Y N

If so, what medications did he recommend? _____

Is this the child's first dental appointment? Y N _____

Were there any special problems at last dental visit? Y N _____

Is there a specific dental problem now? Y N _____

Has your child ever had the following:

Attention Deficit/Hyperactivity	Y	N	Heart Problems	Y	N
High Blood Pressure	Y	N	Asthma	Y	N
Bleeding Problems	Y	N	Rheumatic Fever	Y	N
Sickle Cell Anemia	Y	N	Diabetes	Y	N
Epilepsy	Y	N	Heart Murmur	Y	N
Hepatitis	Y	N	Positive HIV	Y	N
Improper Bite	Y	N	Pregnant	Y	N

Please describe any other medical or dental problems not listed?

_____

Who is the child's Physician? _____

Who was the child's previous dentist? _____

This information was given by? _____

A. I certify that the above information is correct, and I am responsible for this minor child. I hereby grant permission for the doctor to perform dental treatment for this child.
B. It is understood that all records, appliances, models, radiographs and photographs taken in and during the examination and treatment remain in the property of Dallas Dental Care.
C. As the responsible party, I understand that all payments are due at the time service is rendered**, unless other arrangements have been made in advance.** Dallas Dental Care has my permission to run a credit check. Should I fail to fully comply with any financial arrangements, I agree to pay financial charges that will be added to my account. I understand that if my account is taken before a collection agency or attorney for any reason, I am responsible for ALL collections and/or attorney fees.

Signature: _____ Date _____