CHILD REGISTRATION

Child's Name ____________________ Nickname ____________________

Street Address ____________________ City ____________ State ________ Zip ________

Sex ☐ M ☐ F Age ________ Birthdate ____________ Home Phone ( ) ____________

School ____________ Favorite Sport? ____________ Hobby? ____________

Parent Information

Father's Name ____________________ Father's Employer ____________________

Father's SS# ____________ Father's Birthdate ____________ Lic. # ________ Work # ________

Mother's Name ____________________ Mother's Employer ____________________

Mother's SS# ____________ Mother's Birthdate ____________ Lic. # ________ Work # ________

Primary Dental Insurance

Insured's Full Name ____________________ Relationship to Patient ____________________

Insured's Date of Birth ____________________ Insured's SSN ____________________

Insured's Employer ____________________ Dental Insurance Co. ____________________

Group # ____________________ Employee ID # ____________________

Secondary Dental Insurance

Insured's Full Name ____________________ Relationship to Patient ____________________

Insured's Date of Birth ____________________ Insured's SSN ____________________

Insured's Employer ____________________ Dental Insurance Co. ____________________

Group # ____________________ Employee ID # ____________________

We will file secondary insurance only if your primary insurance sends our office an explanation of benefits.

We cannot wait on payment from the secondary carrier.

Next of Kin / Person to Contact in Case of Emergency

Name : ____________________ Relationship to Patient : ____________________

Home Phone ( ) ____________________ Work Phone ( ) ____________________

Home Address ____________________ City ____________ State ____________ Zip ____________

Who may we thank for referring you to our office? ____________________

I authorize Madison Dental Associates, P.C. to release any information necessary to process my insurance claim and authorize payment to the provider. I am financially responsible for any services both covered and non-covered by insurance.

Date ____________________ Parent's Signature ____________________

Child Medical History

Pediatrician's Name ______________________ Date of Last Physical ______________

Has your Child ever had any of the following? (check boxes that apply):

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Congenital Heart Defect
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valves or Joints
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Cancer
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ "A.I.D.S." or other
- ☐ Immunosuppressive Disorders

Is your child allergic to any medicine or drugs? ______________ If so, what? ______________________

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Is your child presently taking any medicines? ______________ If so, what? ______________________

Is your child presently being treated by a physician? ______________________

For what conditions? ______________________

Dental History

Has your child ever been seen by a dentist? . . . . Yes ☐ No ☐

Please check if your child has (or had):

☐ Toothache ☐ Teeth Bumped ☐ Bleeding Gums ☐ Sensitive Teeth ☐ Discolored Teeth ☐ Other