

COLLINS DENTISTRY FOR CHILDREN

100 BRIDGE STREET, PO BOX 728

PELHAM, NH 03076-0728

Telephone: (603) 635-1166

Nilfa Collins, D.M.D.

CHILD'S REGISTRATION AND HISTORY

Child's Name _____ Prefers to be called _____
first middle last
Sex Male Female Birthdate _____ Age _____ School _____ Grade _____
Is this an emergency visit? Y N
Is this your child's first dental visit? Y N
If no, name of former dentist _____ Date of last visit _____ Purpose _____
Have any other children in your family been a patient in this office before? Y N
Reason for this visit? _____
Has your child had any bad past dental experiences? Y N Please explain _____
Names and ages of siblings: _____
Name of child's pet _____ Favorite interest _____ Favorite sport _____
Name of Parent's Dentist _____
Whom may we thank for referring you to our office? _____

GENERAL INFORMATION

Father's Full Name _____	Mother's Full Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
S.S.# _____ Birthday _____	S.S.# _____ Birthday _____
Employed by _____	Employed by _____
Occupation _____	Occupation _____
Bus. Address _____	Bus. Address _____

Child lives with both parents mother father other
E-mail address (for use when sending child's picture) _____

I understand that overdue balances are subject to interest and collection charges

Signature of parent _____

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber's Name _____	Subscriber's Name _____
Group/Policy Number _____	Group/Policy Number _____
Employer Name _____	Employer Name _____
Insurance Company _____	Insurance Company _____
How long have you had this coverage? _____	How long have you had this coverage? _____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I authorize release of any information relating to this claim.

Signature of patient (or parent if minor)

I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

Signature of insured person

MEDICAL INFORMATION

Child's Pediatrician _____
 Address _____ Phone _____ Date of last physical _____

Yes No

Is your child in good health? Yes No

Are your child's immunizations up to date? Yes No

Prior to receiving dental work, does your child require pre-medication? Yes No

Is your child being treated for any condition presently? Yes No

If so, please explain _____

Is your child taking any medication or drugs? Yes No

If so, please explain _____

Has your child ever been hospitalized or had surgery? Yes No

If so, please explain _____

Does your child have any allergies or reaction to any medications? Yes No

If so, please explain _____

Does your child have any allergies to the following?
 pollen food food dyes dust latex other _____

Has your child ever been diagnosed as having any of the following conditions? Please check yes(Y) or no (N):

Y N	Y N	Y N
<input type="checkbox"/> AIDS or HIV	<input type="checkbox"/> Cleft Lip/Palate	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Autism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutritional Deficiency
<input type="checkbox"/> Bladder Conditions	<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Oral Ulcers
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Excessive Bleeding Problems	<input type="checkbox"/> Premature Birth
<input type="checkbox"/> Bone or Joint Problems	<input type="checkbox"/> Excessive Gagging	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Fainting or Dizziness	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Growth & Development Problems	<input type="checkbox"/> Sick Cell Anemia
<input type="checkbox"/> Cancer or Malignancies	<input type="checkbox"/> Hearing/Speech Problems	<input type="checkbox"/> Syndrome _____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Child Abuse	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chronic Adenoid/Tonsil Infection	<input type="checkbox"/> Hepatitis or Liver Disease	_____
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Hyperactivity/A.D.D./A.D.H.D	_____
<input type="checkbox"/> Chronic Ear Infections		_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been covered. _____

DENTAL INFORMATION

	Y	N	
Was your child bottle fed?	<input type="checkbox"/>	<input type="checkbox"/>	if yes, until what age _____
Was your child breast fed?	<input type="checkbox"/>	<input type="checkbox"/>	if yes, until what age _____
Has your child ever had any injuries to his teeth, mouth, head or jaws?	<input type="checkbox"/>	<input type="checkbox"/>	if yes, please describe _____
Does your child brush daily?	<input type="checkbox"/>	<input type="checkbox"/>	Type of brush <input type="checkbox"/> hard <input type="checkbox"/> soft
Does an adult assist with the brushing?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child floss daily?	<input type="checkbox"/>	<input type="checkbox"/>	
Does an adult assist with the flossing?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your child have any of the following mouth habits?			<input type="checkbox"/> finger sucking <input type="checkbox"/> thumb sucking <input type="checkbox"/> tongue thrusting <input type="checkbox"/> pacifier <input type="checkbox"/> lip sucking <input type="checkbox"/> teeth grinder <input type="checkbox"/> mouth breather <input type="checkbox"/> bites nails
Does your child report any pain during chewing or while opening the mouth wide?			<input type="checkbox"/> yes <input type="checkbox"/> no
Does your child receive flouride in any of the following forms:			
<input type="checkbox"/> in vitamins			<input type="checkbox"/> in water supply
<input type="checkbox"/> in tablets/drops			Dosage: _____ mg/day
			<input type="checkbox"/> in toothpaste <input type="checkbox"/> in rinse/gel

CONSENT FOR TREATMENT

I hereby authorize and direct Dr. Collins, her associates, and their dental auxiliary staff to provide dental care for my child. I understand that I will be provided with answers to any questions which may arise during the course of my child's treatment.

Patient's Name _____ Date _____
 Signature of Parent or Guardian _____