

**SWIFT CREEK DENTAL CENTER
CHILD REGISTRATION & HISTORY**

Patient's Name _____ **Nickname** _____

D.O.B. _____ **Age** _____ **Sex (M or F)** _____ **SS#** _____

Father's Name _____ **Marital Status** _____

SS# _____ **D.O.B.** _____ **Home # ()** _____

Street Address _____ **Zip** _____

Employer Name _____ **Work Phone ()** _____

Mother's Name _____ **Marital Status** _____

SS # _____ **D.O.B.** _____ **Home # ()** _____

Street Address _____ **Zip** _____

Employer Name _____ **Work Phone ()** _____

Name of Insurance Company _____

Address _____ **Phone ()** _____

Subscriber Name _____

SS#/Subscriber # _____ **Group #** _____

Secondary Insurance Company _____

Address _____ **Phone ()** _____

Subscriber Name _____

SS#/Subscriber # _____ **Group #** _____

With whom does the child live? _____

How did you find out about our office? _____

Child's Hobby/Sport _____ **Favorite Person** _____

HEALTH HISTORY

Child's Physician _____ **Phone** _____

Address _____ **Date of Last Exam** _____

Results _____

DOES CHILD HAVE ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING?

- | | | | | |
|---|--|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mono | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Cerebral Palsy | | <input type="checkbox"/> Fainting | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Chicken Pox | | | | |

SUMMARY:

Please notify us 24 hours in advance if you must cancel your appointment. This allows us to schedule other patients in that time slot. There may be a charge for missed appointments without advanced cancellation notice.

We are happy to file your dental insurance claims. However it is your responsibility to provide the insurance information for each child at each visit, and follow up on any unpaid claims. Deductibles and co pays are requested and appreciated at the time services are rendered. Furthermore, any amount not paid by insurance is due from you on the day that services are rendered. Financial terms include cash, check, and most major credit cards. Delinquent accounts of 30 days or more carry a 1.5% per month service charge, with a minimum \$2.00 fee per month. I understand I am responsible for any collections, court costs, and attorney fees this account may incur.

This information was discussed with and given by _____

Relation to Child _____

Signature _____ **Date** _____