CHILDREN'S DENTAL HEALTH CENTER
966-C PARK STREET
STOUGHTON, MA 02072
TELEPHONE (781) 341-0030

Derek Zurn, D.D.S., M.S.
& ASSOCIATES
Pediatric Dentistry

CHILD'S REGISTRATION AND HISTORY

Child's Name _____ Birth Date _____ Age _____
first middle last

Sex ❑ Male ❑ Female Nickname _____ 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 number of children in family: _____

Present dental problem as you see it (if any) _____

Has your child had any bad past dental experiences: ❑ Yes Explain _____

Name of Child's pet _____ Favorite interest _____ Favorite Sport _____

Name of parent's dentist _____

Who referred you to our office? Name _____ Street _____ City _____

❑ Doctor ❑ Friend/Relative ❑ Yellow Pages ❑ Mail ❑ Other

GENERAL INFORMATION

Father's Full Name _____

Home Address _____

City _____ Zip _____

Phone (_____) _____ _____ D.O.B. _____

Cell (_____) _____ _____ Email: _____

SS# _____ Occupation _____

Employer _____

Bus. Address _____ Bus. Phone _____

Mother's Full Name _____

Home Address _____

City _____ Zip _____

Phone (_____) _____ _____ D.O.B. _____

Cell (_____) _____ _____ Email: _____

SS# _____ Occupation _____

Employer _____

Bus. Address _____ Bus. Phone _____

Child lives with ❑ both parents ❑ mother ❑ father ❑ other

INSURANCE

Primary
Subscriber Name _____
Grp / Policy # _____
Insurance Co. _____

Secondary
Subscriber Name _____
Grp / Policy # _____
Insurance Co. _____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.
I have reviewed the following treatment plan. I authorize release of any information relating to this claim.
I hereby authorize payment directly to Children's Dental Health Center.

_____
Signed insured person

PAYMENT POLICY

Payment / co-payment is due at time services are rendered.

Our office will submit insurance forms for you, however submission of forms is not a guarantee of payment. **You, as parent, are ultimately responsible for all treatment charges.**

_____
Signature of responsible party

please complete the reverse side

MEDICAL INFORMATION

Child's Pediatrician _____ Address _____ Phone _____

Date of last physical? _____

	Yes	No
1. Is your child in good health?	❑ 1	❑
2. Are your child's immunizations up to date?	❑ 2	❑
3. Is your child being treated for any condition presently?	❑ 3	❑
If so, explain _____		
4. Is your child taking any medications or drugs?	❑ 4	❑
If so, explain _____		
5. Has your child ever been hospitalized or had surgery?	❑ 5	❑
If so, explain _____		
6. Does your child have any allergies or reactions to any medications?	❑ 6	❑
If so, explain _____		

7. Does your child have any allergies to the following?

❑ pollen ❑ food ❑ food dyes ❑ dust ❑ other _____

9. Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
❑	❑	AIDS	❑	❑	Cleft Lip/Palate	❑	❑	Kidney Disease
❑	❑	Anemia	❑	❑	Congenital Heart Disease	❑	❑	Leukemia
❑	❑	Asthma	❑	❑	Convulsions/Seizures	❑	❑	Intellectual Disability
❑	❑	Autism	❑	❑	Diabetes	❑	❑	Nutritional Deficiency
❑	❑	Bladder Conditions	❑	❑	Emotional Disturbance	❑	❑	Oral Ulcers
❑	❑	Blood Transfusions	❑	❑	Epilepsy	❑	❑	Orthopedic Problems
❑	❑	Birth Defects	❑	❑	Eye Problem	❑	❑	Premature Birth
❑	❑	Bone or Joint Problems	❑	❑	Excessive Bleeding Problem	❑	❑	Rheumatic Fever
❑	❑	Brain Injury	❑	❑	Excessive Gagging	❑	❑	Scoliosis
❑	❑	Bruising Easily	❑	❑	Fainting or Dizziness	❑	❑	Sickle Cell Anemia
❑	❑	Cancer or Malignancies	❑	❑	Growth & Development Problems	❑	❑	Syndrome _____
❑	❑	Cerebral Palsy	❑	❑	Hearing/Speech Problems	❑	❑	Tuberculosis
❑	❑	Child Abuse	❑	❑	Heart Murmur	❑	❑	Other _____
❑	❑	Chronic Adenoid/Tonsil Infection	❑	❑	Hemophilia			_____
❑	❑	Chronic Headaches	❑	❑	Hepatitis or Liver Disease			_____
❑	❑	Chronic Ear Infections	❑	❑	HIV Positive			
			❑	❑	Hyperactivity			

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	
1. Was your child bottle fed?	❑ 1	❑	If yes, until what age _____
2. Was your child breast fed? If yes, until what age	❑ 2	❑	If yes, until what age _____
3. Has your child ever had any injuries to his teeth, mouth, head or jaws?	❑ 3	❑	If yes describe _____
4. Does your child brush daily?	❑ 4	❑	
5. Does an adult assist with the brushing?	❑ 5	❑	
6. Does your child floss daily?	❑ 6	❑	
7. Does an adult assist with the flossing?	❑ 7	❑	

8. Does your child have any of the following mouth habits?

❑ finger sucking ❑ thumb sucking ❑ pacifier ❑ tongue thrusting

❑ lip sucking ❑ mouth breather ❑ teeth grinding ❑ bites nails

9. Does your child report any pain during chewing or while opening the mouth wide	Yes ❑ 9.	No ❑		
10. Does your child report any discomfort in the jaws or neck region?	Yes ❑ 10.	No ❑		
11. Is there a history of trauma to the jaws or neck region?	Yes ❑ 11.	No ❑		
12. Does your child"s jaw "click" or lock upon opening?	Yes ❑ 12.	No ❑		

13. Does your child receive fluoride in any of the following forms:

❑ in vitamins ❑ in water supply ❑ in tablets/drops Dosage:_____ mg/day ❑ in toothpaste ❑ in rinse/gel

Please check any of the following that may describe your child?

❑ Outgoing ❑ Shy ❑ Stubborn ❑ Anxious ❑ Frightened ❑ Defiant

❑ Curious ❑ Moody ❑ High Strung ❑ Regular Kid ❑ Friendly ❑ Cooperative

How do you expect your child to react to his visit today?

❑ excellent ❑ good ❑ fair ❑ poor ❑ don't know

How may we help to make this a positive experience for your child _____

_____

CONSENT FOR TREATMENT

I hereby authorize and direct Dr. Zurn and his 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.

Patients Name _____

Signature of Parent or Guardian _____ Date _____