Joseph Chan, DDS **Dentistry for Children** Mary Ann Michael, DDS
850 I St.
Sparks, NV 89431

CHILD REGISTRATION AND HEALTH HISTORY

NAME OF CHILD _____ BORN _____ AGE _____
(Last / First / Inital) (Month / Day / Year)

■ MALE ■FEMALE

NICKNAME _____ SOC. SEC. # _____

Is this child's first visit to a dentist? _____ If not, when was last visit? _____

	YES	NO
1. Is your child presently under the care of a physician for any medical problem? What?	■	■
2. Is your child currently taking medication, including birth control? What?	■	■
3. Has your child ever been hospitalized or had surgery? For what?	■	■
4. Is your child allergic to any food or medicine? What?	■	■
5. Any mouth habits, thumbsucking, etc.?	■	■

6. Are there any other children in family _____ ? If so, how many _____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY PHYSICAL, MENTAL OR EMOTIONAL CONDITION? WHAT?

Yes	No		Yes	No		Yes	No	
■	■	Asthma or chronic respitory condition	■	■	Allergies	■	■	Bleeding problems
■	■	Drug Sensitivities	■	■	Brain Injury	■	■	Seizures/ Convulsion
■	■	Heart trouble or murmurs	■	■	Sleep apnea (stops breathing)	■	■	Epilepsy
■	■	Rheumatic fever	■	■	Premature birth	■	■	Diabetes
■	■	Blood disorders	■	■	Tuberculosis	■	■	Kidney/Liver involvement
■	■	Hepatitis	■	■	HIV (AIDS)	■	■	MRSA

■ ■ Other _____

PARENTS COMMENTS _____

LEGAL GUARDIAN OR _____
FATHER'S NAME _____
ADDRESS _____
CITY, STATE ZIP _____
EMPLOYER _____
OCCUPATION _____
HOME PHONE _____ CELL _____
SOCIAL SECURITY NUMBER _____
BIRTHDATE: _____
E-MAIL: _____

LEGAL GUARDIAN OR _____
MOTHER'S NAME _____
ADDRESS _____
CITY, STATE ZIP _____
EMPLOYER _____
OCCUPATION _____
HOME PHONE _____ CELL _____
SOCIAL SECURITY NUMBER _____
BIRTHDATE: _____
E-MAIL: _____

Whom may we thank for referring you? _____
Is your dental work covered by insurance? ■ Yes ■ No. If yes please complete insurance information.

INSURANCE INFORMATION:

EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE SELF ○ SPOUSE ○ CHILD ○ OTHER ○	SEX M ○ F ○	PATIENT BIRTHDATE MO. DAY YEAR	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE MO. DAY YEAR
EMPLOYER (COMPANY) NAME AND ADDRESS	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER	

DUAL COVERAGE INFORMATION:

EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE SELF ○ SPOUSE ○ CHILD ○ OTHER ○	EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE MO. DAY YEAR	
EMPLOYER (COMPANY) NAME AND ADDRESS	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OR CARRIER

Can you be available for short notice appointments should we have an unexpected opening? ■ Yes ■ No

Which days? _____ What times? _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

_____ _____
SIGNED (PATIENT, PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____
SIGNED (INSURED PERSON) DATE