MONTGOMERY
pediatric dentistry

Registration

Date:_______________

Child #1 Name:____DOB:___/___/___
Child #2 Name:____DOB:___/___/___
Child #3 Name:____DOB:___/___/___
Child #4 Name:____DOB:___/___/___
Child #5 Name:____DOB:___/___/___
Home address:____
Home phone: (____)______________________

☐ **Father** ☐ **Mother**	☐ **Father** ☐ **Mother**
Name:____________________________________	Name:____________________________________
Address:☐same_____________________________	Address: ☐ same_____________________________
Cell Phone: (_______)____________________	Cell Phone: (_____)____________________
SSN:______________________DOB:____/____/____	SSN:____________________DOB:____/____/____
Occupation:________________________________	Occupation:________________________________
Employer:__________________________________	Employer:__________________________________
Business Phone:____________________________	Business Phone:____________________________
Dental Insurance:___________________________	Dental Insurance___________________________

How did you find out about our office:__________________________________

<u>Consent for treatment:</u> I authorize the performance of any necessary dental treatment recommended by this office for the above named patient(s) and will be responsible for payment of this account.

Sign:________________________________**Date:**__________**Relationship to Child(ren)**________________

MONTGOMERY pediatric dentistry

Medical and Dental History

Date:________________

Child's Name ______________________________________ Name child goes by: ___________________________

Child's Birthdate:_______________________ Age:______________ Gender:____Male ____Female

Dental Insurance: ☐ Father's Insurance ☐ Mother's Insurance ☐ Other:______________________________

Child's Interest Or Hobbies____

School____Grade______________________________

Purpose of this Appointment: ☐ Checkup ☐ Trauma ☐ Cavities ☐ Pain ☐ 2nd Opinion
Other:____

Comments regarding today's appointment:____

Has Your Child Had any Unhappy Dental Visits? ☐ Yes ☐ No Explain:_______________________________
How Often are Child's Teeth Brushed? ☐ Morning ☐ Bedtime ☐ Other __________ By Whom:____________
Does Child Use Dental Floss? ☐ Yes ☐ No How often:_______________________
Any Previous Injuries to: ☐ Teeth ☐ Mouth ☐ Jaws ☐ Head Describe_______________________________
Any Mouth Habits: ☐ Thumb or Finger Sucking ☐ Pacifier ☐ Nail Biting ☐ Other ______________________

Name of Child's Physician:____

Has Your Child Ever Had Any of the Following:

☐ Allergies	☐ Tuberculosis	☐ Hepatitis	☐ Developmental Delay
☐ Anemia	☐ Hearing Impairment	☐ Kidney Conditions	☐ Sensory Processing Disorder
☐ Asthma	☐ Eye Problems	☐ Liver Conditions	☐ Handicap Conditions
☐ Abnormal Bleeding	☐ Heart Disease/Murmur	☐ ADD/ADHD	☐ Down Syndrome
☐ Cancer	☐ Hypertension	☐ Autism	☐ Seizures
☐ Immune Deficiency	☐ Cleft Lip/ Cleft Palate	☐ Asperger's	☐ Emotional Problems
☐ Diabetes	☐ Reflux/ GI problems	☐ Speech Delay	☐ Other
☐ Tongue Tie/Lip Tie	☐ Tourette's Syndrome	☐ MTHFR mutation	

If Any of the Above are Checked, Please Explain:
____
____
____

List any medications your child is taking:____
____

Does Your Child Have Any Special Problems Not Listed:
____
____
____

Signature of Parent/Guardian: Relationship to patient:
____