

CHILD REGISTRATION HISTORY

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DATE _____

BIRTHDATE _____

PATIENT'S NAME _____
First Middle Last SOCIAL SECURITY NUMBER

NAME OF MOTHER _____
First Middle Last SOCIAL SECURITY NUMBER

NAME OF FATHER _____
First Middle Last SOCIAL SECURITY NUMBER

STREET ADDRESS _____ **PHONE** _____

CITY _____ STATE _____ ZIP _____

MOTHER/FATHER ADDRESS IF DIFFERENT THAN ABOVE

STREET ADDRESS _____ **PHONE** _____

CITY _____ STATE _____ ZIP _____

FATHER EMPLOYED BY _____ **PHONE** _____

PRESENT POSITION _____ HOW LONG HELD _____

BUSINESS ADDRESS _____

MOTHER EMPLOYED BY _____ **PHONE** _____

PRESENT POSITION _____ HOW LONG HELD _____

BUSINESS ADDRESS _____

IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED OTHER THAN IMMEDIATE FAMILY _____

_____ **PHONE** _____

WHO WILL PAY THIS ACCOUNT _____

WHOM MAY WE THANK FOR REFERRING YOU _____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

POLICY #/GRP _____

ID # _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

POLICY #/GRP _____

ID # _____

DENTAL HISTORY

- 1. Is this the child's first visit to a dentist?YES NO
- 2. If not, how long since the last visit to the dentist? _____
- 3. When was the last time the teeth were cleaned? _____
- 4. Does child eat between meals?.....YES NO
- 5. Does child eat sweets, such as candy, soda pop, chewing gum?YES NO
- 6. Does child eat well balanced meals?YES NO
- 7. Does child brush teeth upon arising?.....YES NO
 - When going to bed?YES NO
 - Right after eating meals?YES NO
 - After eating any food?.....YES NO
- 8. Do you live in an area without fluoridated water?YES NO
- 9. Have teeth been treated with fluorides?YES NO
- 10. Have any cavities been noted in the past?YES NO
- 11. Were any teeth (baby or permanent) removed by extraction?YES NO
- 12. Have there been any injuries to teeth, such as falls, blows, chips, etc?.....YES NO
- 13. Has child had any unfavorable dental experiences?YES NO
- 14. How many children in your family? _____
- 15. Has anyone in the family, including parents, had orthodontics?YES NO
- 16. Has child ever received a local anesthetic or any form of anesthetic?YES NO
- 17. Has child ever had occlusal sealants?YES NO

MEDICAL HISTORY

- 1. Is child in good health?YES NO
- 2. Is child under care of physician?YES NO
 - If yes, since when _____ Why _____
- 3. Name of physician _____
- 4. Is child receiving any medication?YES NO
 - What _____
 - When _____ Why _____
- 5. Has the child had any serious illness?YES NO
 - When _____
- 6. Is the child allergic to penicillin antibiotics, or other drugs?YES NO
- 7. Does the child have any other allergies?YES NO
- 8. Has child had surgery?YES NO
- 9. Is child subject to profuse bleeding?YES NO
- 10. Is child subject to nervous disorders?YES NO
 - Fainting?YES NO
 - Dizziness?YES NO
- 11. Is child pregnant or suspect she may be?YES NO
- 12. Has child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

COMMENTS

PLEASE READ AND SIGN

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for Insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of Insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care Insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this form.

I understand that responsibility for payment of Dental services provided in this office for myself or my dependents is mine due and payable at the time services are rendered. I further understand that a rebilling fee of \$2.00 will be added to any balance over 60 days.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____