RAND CENTER FOR DENTISTRY

Child Registration

Tell us about your child

Today's Date: _____

Child's Name: _____

Birthdate: _____ Child's Age: _____

Preferred Name: _____ ❒ Male ❒ Female

Child's Home #: _____

Child's Home Address: _____

_____

_____

Previous / Present Dentist: _____

Last Visit Date: _____

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❒ Yes ❒ No

Is the child adopted? ❒ Yes ❒ No

Is the child in a foster home? ❒ Yes ❒ No

List brothers / sisters, with age: _____

_____

Whom may we thank for referring you?

❒ Dentist ❒ Internet ❒ Advertisement

❒ Friend _____

❒ Other _____

Parental Information

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Partnered ❒ Separated

❒ Parent ❒ Step Parent ❒ Guardian

Name: _____

Address (if different): _____

Birthdate: _____ Home #: _____

Work #: _____ Cell #: _____

Occupation: _____

E-Mail: _____

❒ Parent ❒ Step Parent ❒ Guardian

Name: _____

Address (if different): _____

Birthdate: _____ Home #: _____

Work #: _____ Cell #: _____

Occupation: _____

E-Mail: _____

Primary Dental Insurance

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Insurance Co. Name: _____

Insurance Policy ID #: _____

Policy Owner's Employer: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Insurance Co. Group #: _____

Secondary Dental Insurance

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____

Insurance Co. Name: _____

Insurance Policy ID #: _____

Policy Owner's Employer: _____

Insurance Co. Address: _____

_____

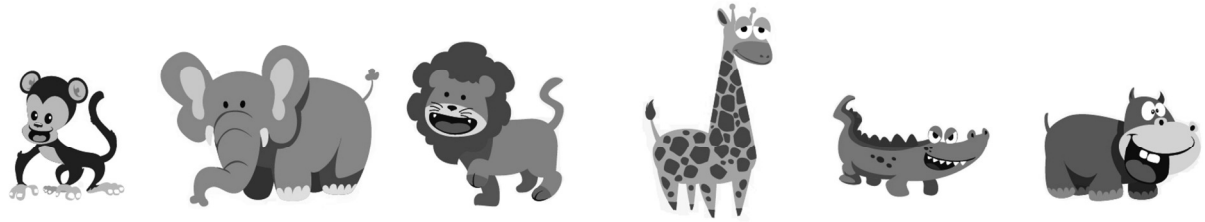
Insurance Co. Phone #: _____

Insurance Co. Group #: _____

I certify that my child is covered by the above Insurance Co. and I assign directly to Rand Dental Associates, P.A. all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible which my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

X _____ _____

Signature of Parent or Guardian Date



RAND CENTER FOR DENTISTRY

Child Medical & Dental History

Child Name: _____ **DOB:** _____

Why did you bring the child to the dentist today?

_____

_____

Has your child ever had a serious / difficult problem associated with previous dental work? **Y** **N**

If yes, please explain: _____

_____

Is your child's water fluoridated? **Y** **N**

Is your child taking fluoridated supplements? **Y** **N**

Has the child ever had any pain / tenderness in their jaw joint (TMD / TMJ)? **Y** **N**

Does the child brush their teeth daily? **Y** **N**

Does the child floss their teeth daily? **Y** **N**

Is the child currently under care of a physician? **Y** **N**

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

What is the child's overall current physical health?

Good **Fair** **Poor**

Please list all medications the child is currently taking:

_____

_____

Is the child allergic to Latex? **Y** **N**

Allergic to Metals / Nickel? **Y** **N**

Allergic to Plastic? **Y** **N**

Please list all additional things & medications they are allergic to:

_____

_____

Has the child ever had any of the following medical problems?

❒ Abnormal Bleeding	❒ Handicaps / Disabilities
❒ ADD / ADHD	❒ Hearing / Vision Loss
❒ Anemia	❒ Heart Murmur
❒ Any Hospital Stays	❒ Hemophilia
❒ Any Operations	❒ Hepatitis
❒ Artificial Bones / Joints / Valves	❒ Hives
❒ Asthma	❒ HIV Positive / AIDS
❒ Autism / Asperger's / PDD	❒ Kidney / Liver Problems
❒ Cancer	❒ Measles
❒ Chicken Pox	❒ Mononucleosis
❒ Congenital Heart Defect	❒ Rheumatic / Scarlet Fever
❒ Convulsions	❒ Sensory Issues
❒ Diabetes	❒ Sickle Cell Disease / Traits
❒ Epilepsy	❒ Skin Rash
❒ Exposed to HIV, but Negative	❒ Tuberculosis (TB)

Are the child's immunizations / vaccines current? **Y** **N**

Was the child breast fed? **Y** **N**

Anything to discuss with the doctor in private? **Y** **N**

Does or did the child have any of the following habits?:

Lip Sucking / Biting ❒ Nursing Bottle Habits ❒

Nail Biting ❒ Thumb / Finger Sucking ❒

Please discuss any serious medical problems the has had:

_____

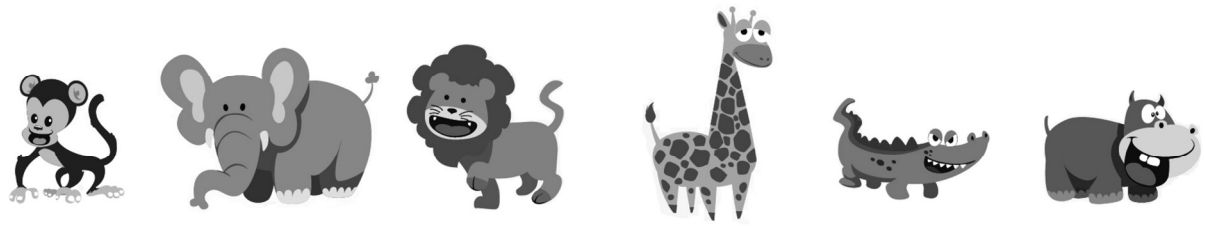
_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform Rand Dental Associates, P.A. of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

X _____ _____

Signature of Parent or Guardian Date



Rand Center for Dentistry

Elliot J. Rand, D.D.S.
General, Laser & Cosmetic Dentistry • Lic. #D1 16358

AUTHORIZATION FOR A DESIGNATED ADULT TO CONSENT FOR AND ACCOMPANY A MINOR PATIENT

(This form must be signed in the Dental Clinic or in front of a Notary Public)

I, _____, the father/mother/legal guardian of _____
(name of parent/guardian) (circle one) (name of child)

authorize _____ to accompany my child (or legal ward for whom
(adult 18 years or older who will accompany child)

I am empowered) to consent; and to give consent for any necessary dental procedures. This authorization will remain in effect until such time as I give notice of its termination.

_____ _____ _____
Signature of parent/legal guardian Signature of witness/Notary Public Date

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AUTORIZACION PARA UN ADULTO AUTORIZAR Y ACOMPAÑAR UN PACIENTE MENOR DE EDAD

(Esta planilla debe ser firmada en la clinica dental o frente a un Notario Publico)

Yo, _____, padre/madre/guardian legal de _____
(Nombre de padre o guardian legal) (marque con un círculo) (Nombre de paciente menor de edad)

autorizo a _____ acompañar a mi niño(a) (o el niño(a) de quien
(Adulto de 18 angs a mayor quien acompanara al nino(a))

tengo custodia legal) y dar autorizacion para cualquier tratamiento dental que sea neccesario. Esta autorizacion quedara on vigor hasta que yo elija negarlo.

_____ _____ _____
Firma padre o guardian legal Firma testigo o Notario Publico Date

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