



Comments: _____

Sealants
Ortho Eval

REGISTRATION AND HEALTH UPDATE

Child's Name: _____

Date of Birth: _____

Parent's / Guardian Name: _____

Address: _____

Patient Email: _____

Parent's Email: _____

Mom's Cell # _____

Dad's Cell # _____



Medical alerts currently on file: _____

Please answer the following questions:

- 1. Has your child seen their physician since your last visit? Yes__ No__
If so why? _____
- 2. Does your child have any sleeping, snoring, or breathing issues? Yes__ No__
If so, what? _____
- 3. Change in medical history? Any Hospitalizations or Surgeries? Yes__ No__
If so, how/what? _____
- 4. Is your child currently taking any medications? Yes__ No__
If so, what and why? _____
- 5. Has your child received all routine vaccinations or any injections? Yes__ No__
If so, what? _____
- 6. Any injury to the head or neck in the last six months? Yes__ No__
If so, what? _____
- 7. Any dental or medical problems that you are aware of? Yes__ No__
If so, what? _____
- 8. Does your child need a new fluoride vitamin prescription? Yes__ No__
- 9. What school does your child attend? _____
- 10. What is your relationship with the patient? _____

Did your dental insurance Change since your last visit? If so please provide info below:

Member Name _____ DOB ____/____/____

Employer _____

Carrier Name & Address _____

KidZdent follows Federal and State Law by complying with HIPPA standards. Our Notice of Policy Practices is available to you at your request.

I certify that I have read and understood the above and I understand that the information that I have given is correct to the best of my knowledge. I will not hold **KidZdent** or any member of the staff responsible for any errors or omissions I may have made in the completion of this form. I also authorize the Doctor and staff of **KidZdent** to perform the necessary dental services they have explained to me.

Parent's signature _____

Date _____