CHILD REGISTRATION

DATE ______________

CHILD'S NAME: ______________ BIRTHDATE ______________ AGE ______________

NICKNAME ______________ HOBBIES ______________

PARENT'S NAME ______________

RESIDENCE/STREET ______________

CITY ______________ STATE ______________ ZIP ______________

SCHOOL ______________

PHONE: RESIDENCE ______________ SCHOOL ______________

FATHER EMPLOYED BY ______________

PRESENT POSTION ______________ HOW LONG HELD ______________

MOTHER EMPLOYED BY ______________

PRESENT POSTION ______________ HOW LONG HELD ______________

REFERRED BY ______________

WHO WILL PAY THIS ACCOUNT ______________

PURPOSE OF CALL ______________

FATHER'S DENTAL INSURANCE CO: ______________

POLICY # ______________

MOTHER'S DENTAL INSURANCE CO: ______________

POLICY # ______________

PARENTS' SOCIAL SECURITY NUMBERS:

FATHER ______________ MOTHER ______________

PARENTS' BIRTHDATES:

FATHER ______________ MOTHER ______________

INFORMATION FOR EMERGENCY TREATMENT

DOES THE CHILD HAVE OR HAS CHILD EVER HAD

Y	N	
☐	☐	ANEMIA
☐	☐	DIABETES
☐	☐	HEPATITIS
		ALLERGIES
☐	☐	------- TO PENICILLIN
☐	☐	------- TO LOCAL ANESTHETIC
☐	☐	ABNORMAL HEART CONDITION
☐	☐	ABNORMAL BLEEDING FROM A CUT
☐	☐	RHEUMATIC FEVER
☐	☐	HEART MURMUR
☐	☐	IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN NOW
☐	☐	IS ANY MEDICATION BEING TAKEN NOW

IF SO, WHAT

____

____

OTHER PHYSICAL CONDITIONS

____

____

NAME OF PHYSICIAN

____

TELEPHONE NUMBER

____

INFORMATION GIVEN BY (SIGNATURE)

____

DATE	SERVICE RENDERED	CHARGE	CREDIT	BALANCE