

LLOYD B. AUSTIN, D.D.S., LTD.
PEDIATRIC DENTIST
 For Children, Teens and the Handicapped

CHILD REGISTRATION AND HEALTH HISTORY

NAME OF CHILD _____ BORN _____ AGE _____
Last First Initial Month Day Year

MALE FEMALE

NICKNAME _____

SOC. SEC. # _____

Is this child's first visit to a dentist? _____

If not, when was last visit? _____

1. Is your child presently under the care of a physician for any medical problem? YES NO
 What?
2. Is your child currently taking medication, including birth control? What?
3. Has your child ever been hospitalized or had surgery? For what?
4. Is your child allergic to any food or medicine? What?
5. Any mouth habits, thumbsucking, etc.?
6. Are there any other children in family _____? If so, how many _____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY PHYSICAL, MENTAL OR EMOTIONAL CONDITION? WHAT?

- | | | |
|--|--|---|
| <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma or chronic respiratory condition</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug Sensitivities</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart trouble or murmurs</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Brain Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep apnea (stops breathing)</p> <p><input type="checkbox"/> <input type="checkbox"/> Premature birth</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV (AIDS)</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures/ Convulsion</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney/Liver involvement</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding problems</p> |
|--|--|---|

PARENTS COMMENTS _____

LEGAL GUARDIAN OR _____
 FATHER'S NAME _____
 ADDRESS _____
 CITY, STATE ZIP _____
 EMPLOYER _____
 OCCUPATION _____
 HOME PHONE _____ BUSINESS _____
 SOCIAL SECURITY NUMBER _____
 BIRTHDATE: _____

LEGAL GUARDIAN OR _____
 MOTHER'S NAME _____
 ADDRESS _____
 CITY, STATE ZIP _____
 EMPLOYER _____
 OCCUPATION _____
 HOME PHONE _____ BUSINESS _____
 SOCIAL SECURITY NUMBER _____
 BIRTHDATE: _____

Whom may we thank for referring you? _____
 Is your dental work covered by insurance? Yes No. If yes please complete insurance information.

INSURANCE INFORMATION:											
EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE			SEX M F	PATIENT BIRTHDATE			EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE		
	SELF	SPOUSE	CHILD OTHER		MO.	DAY	YEAR		MO.	DAY	YEAR
EMPLOYER (COMPANY) NAME AND ADDRESS				DENTAL PLAN NAME			UNION LOCAL	GROUP NO.	NAME AND ADDRESS OR CARRIER		

DUAL COVERAGE INFORMATION:											
EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE			EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE						
	SELF	SPOUSE	CHILD OTHER		MO.	DAY	YEAR				
EMPLOYER (COMPANY) NAME AND ADDRESS				DENTAL PLAN NAME			UNION LOCAL	GROUP NO.	NAME AND ADDRESS OR CARRIER		

Can you be available for short notice appointments should we have an unexpected opening? Yes No

Which days? _____ What times? _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

 SIGNED (PATIENT, PARENT IF MINOR) _____ DATE _____
 I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

 SIGNED (INSURED PERSON) _____ DATE _____