MILPITAS DENTAL CENTER
FAMILY DENTISTRY

Child Registration Form

1101 South Park Victoria Dr, Milpitas, CA 95035 · (408) 263-9343

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Tell Us About Your Child

Today's date

Child's last name | First | MI

Nickname | ☐ Male ☐ Female

Birthday | Child's age | Social Security # | Home phone

Child's home address: Street | City | State | Zip

School | Grade

Whom may we thank for referring you?

Other family members seen by us

Previous / present dentist | Last visit date

Person responsible for account

Name | Relation | Work phone | Home phone

Birthday | Social Security #

Address: Street | City | State | Zip

Mother's Information

Name | ☐ Step mother ☐ Guardian

Birthday | Social Security # | Home phone

Employer | Work phone | Ext.

Insurance company | Phone | Group # (plan, local or policy #)

Ins. Co. address: Street / PO Box | City | State | Zip

Father's Information

Name | ☐ Step father ☐ Guardian

Birthday | Social Security # | Home phone

Employer | Work phone | Ext.

Insurance company | Phone | Group # (plan, local or policy #)

Ins. Co. address: Street / PO Box | City | State | Zip

Dental History

Is this your child's first visit to the dentist? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Has the child ever had any pains/tenderness in his or her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Does the child floss his/her teeth daily? ☐ Yes ☐ No

Have there been any injuries to the teeth, face, or mouth? ☐ Yes ☐ No

Is the child currently under the care of a physician? ☐ Yes ☐ No

If not the first visit, how long since the last visit to the dentist?

Why did you bring the child to the dentist today?

If there was a problem with previous dental work, please explain

If there were injuries, please explain

Child's physician | Phone | Date of last visit

Your child's current physical health ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

Please list all drugs that the child is allergic to:

Medical History

Has the child ever experienced the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Allergies to Latex	☐	☐	Asthma	☐	☐	Handicaps/Disabilities	☐	☐	HIV / AIDS
☐	☐	Abnormal Bleeding	☐	☐	Cancer	☐	☐	Hearing Impairment	☐	☐	Kidney Problems
☐	☐	Allergies to any Drugs	☐	☐	Congenital Heart Defect	☐	☐	Heart Murmur	☐	☐	Liver Disease
☐	☐	Any Hospital Stays	☐	☐	Convulsions/Epilepsy	☐	☐	Hemophilia	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Any Operations	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Tuberculosis (TB)

Please discuss any serious problems that the child has had:

Does the child have any of the following habits?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Lip Sucking/Biting	☐	☐	Nail Biting	☐	☐	Nursing Bottle Habits	☐	☐	Thumb/Finger Sucking

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Parent / guardian signature _____ Date _____

Type your full name, or sign by hand after printing.

I understand photos taken of my teeth, smile, or portrait may be displayed for patient educational purposes.

Parent / guardian signature _____ Date _____

Type your full name, or sign by hand after printing.

The "For Office Use Only" section (insurance verification and doctor's comments) will be completed by our staff at your visit.