Dr Kusz Dental Center
773.792.8008

Child Registration Form

About Your Child

Today's Date: _____ File #: _____

Child'd Name: _____ Child'd Nickname: _____ ☐ Boy ☐ Girl

Child's Birthdate: _____ Age: _____

School: _____ Grade: _____

Child's Home Phone Number: _____ Child's SS#: _____

Child's Address: _____

Street *City* *State* *ZIP Code*

Referred By: _____

If doctor, please give address & phone number

Child'd Family Information

Who is accompanying this child today? _____ Relation to child: _____

Do you have Legal Custody of this Child? ☐ YES ☐ NO

How many Brothers / Sisters? _____ Ages: _____ _____ _____ _____ _____

Mother's Name: _____ ☐ Stepmother ☐ Guardian

Home Address: ☐ *Check if same as Child's*

_____

Street *City* *State* *ZIP Code*

Home Phone #: _____ Work Phone #: _____

Mother's SS#: _____ Date of Birth: _____ Driver's License #: _____

Employer: _____ How long? _____

Employer's Address: _____

Street *City* *State* *ZIP Code*

Father's Name: _____ ☐ Stepfather ☐ Guardian

Home Address: ☐ *Check if same as Child's*

_____

Street *City* *State* *ZIP Code*

Home Phone #: _____ Work Phone #: _____

Father's SS#: _____ Date of Birth: _____ Driver's License #: _____

Employer: _____ How long? _____

Employer's Address: _____

Street *City* *State* *ZIP Code*

Account Information

Name _____ Relation to the child: _____

Billing Address: _____

Street *City* *State* *ZIP Code*

Social Security#: _____ Date of Birth: _____ Driver's License: _____

Work Phone #: _____ Cell Phone #: _____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Credit Card #: _____ Expiration Date: _____ CVV: _____

_____
INITIALS

I herby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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Child's Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Is Child in pain? ☐ NO ☐ YES How long? _____

Please indicate any of the following problems:

Discomfort, clicking or popping jaw	☐ Lost/broken fillings	☐ Stained Teeth	☐ Locking Jaw
Red, Swollen or bleeding gums	☐ Teeth Grinding	☐ Bad Breath	☐ Loose Tooth
Sensitive tooth / teeth or gums	☐ Ringing in ears	☐ Broken/Chipped tooth	
Blisters/Sores in or around mouth	☐ Other(s):		

Does your child reqire pre-medication? ☐ YES ☐ NO ☐ Don't know

Previous Dentist: _____ Phone #: _____

Date of Last Dental Exam: _____ Date of last X-rays: _____

Times a day child brushes? _____ Times a week a child flosses? _____ Is the child water fluoridated? ☐ YES ☐ NO

How would you rate the child's smile? (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Child's Medical History

Is Child taking any of the following medications? ☐ Pain killers (including Aspirin) ☐ Ritalin ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Others: _____

Child Physician *(Doctor's Name or Clinic Name)*: _____ Phone#: _____

_____ Last Medical Exam: _____

Street *City* *State* *ZIP Code*

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y / N Heart Murmur	Y / N Jaw problems TMJ/TMD	Y / N Abnormal Bleeding	Y / N Hepatitis
Y / N Rheumatic fever	Y / N Hearing Problems	Y / N Cleft Lip/Palate	Y / N Tuberculosis TB
Y / N Artificial Heart Valves	Y / N Tonsillitis	Y / N Birth Defects	Y / N Psychiatric Problems
Y / N Congenital Heart Defect	Y / N Respiratory Problems	Y / N High/Low Blood Preassure	Y / N Hyper Active/ADD
Y / N Scarlet Fever	Y / N Asthma/Difficulty Breathing	Y / N Artificial Bones/Joints/Implants	Y / N Cerebral Palsy
Y / N Surgeries/Operations	Y / N Blood Transfusion(s)	Y / N Liver/kidney/Organ Problems	Y / N Hemophilia
Y / N Cancer/Tumors	Y / N Leukemia/Anemia	Y / N HIV+/AIDS/ARC	
Y / N Chemotherapy	Y / N Diabetes/Hypoglycemia	Y / N Fainting/Seisures/Epilepsy	

Please list any other medical condition(s) child has or ever had: _____

Is Child allergic to: ☐ Latex ☐ Penicilin/Amoxicilin ☐ Tetracycline ☐ Dental Anesthetic (Novocaine) ☐ Aspirin ☐ Food allergies ☐ Other(s):

Please rate the Child's health from 1 - 10: _____ Does Child wear contact lenses? ☐ YES ☐ NO

Has this child ever taken the drug Ritalin? ☐ NO ☐ YES/How long? _____ Child's Blood type: _____

Does this child do any of the following? ☐ Thumb/Finger sucking ☐ Tongue Thrusting/Sucking ☐ Heavy snoring ☐ Mouth breathing ☐ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

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Signature of ☐*Patient or Guardian* ☐*Other* *Date*