New Patient
Family Registration Form

500 S. Sepulveda Blvd., Suite 301
Manhattan Beach, CA 90266

1) PARENT OR LEGAL GUARDIAN'S INFORMATION:

Information in this section applies to the main legal caregiver of the child/children

Name: _____
Relationship: _____ Birth Date: _____
Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address: _____
_____

Employer: _____
Work #: _____
Home #: _____
Cell #: _____
SSN: _____ DL #: _____
Email Address: _____

2) SPOUSE OR OTHER LEGAL GUARDIAN'S INFORMATION:

Name: _____
Relationship: _____ Birth Date: _____
Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address: _____
_____

Employer: _____
Work #: _____
Home #: _____
Cell #: _____
SSN: _____ DL #: _____
Email Address: _____

3) HOW DID YOU LEARN ABOUT OUR PRACTICE:

☐ Internet-Yelp
☐ Internet – Google
☐ Facebook Group: _____
☐ Pediatrician: _____
☐ Friend: _____
☐ Community Event: _____
☐ School Visit: _____
☐ Insurance Company: _____
☐ Other: _____

4) WHO WILL BE ACCOMPANYING THE CHILD/CHILDREN TO THEIR APPOINTMENT:

Important Note: The parent or guardian who accompanies the child to the appointment is legally responsible for payment at time of service

Name: _____
Relationship: _____

Do you have legal custody of child/children?
☐ YES ☐ NO

5) PRIMARY DENTAL INSURANCE:

Insurance Name: _____
Insurance Address: _____
_____
Insurance Phone: _____
Group Number: _____

Policy Owner's Name: _____
Relationship: _____
Birth Date: _____
Policy Number/SSN: _____
Employer: _____

6) DUAL (SECONDARY) INSURANCE:

Insurance Name: _____
Insurance Address: _____
_____
Insurance Phone: _____
Group Number: _____

Policy Owner's Name: _____
Relationship: _____
Birth Date: _____
Policy Number/SSN: _____
Employer: _____

7) SIGNATURE:

I understand that the information that I have given is accurate to the best of my knowledge and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services that my children may need.

_____ **Signature of parent or legal guardian**

_____ **Relationship to patient**

_____ **Date**

New Patient
Child Information Form

500 S. Sepulveda Blvd., Suite 301
Manhattan Beach, CA 90266

1) TELL US ABOUT YOUR CHILD:

Child's Name: _____
Nickname: _____ ☐ Male ☐ Female
Child's Birthday: _____ Child's Age: _____
School: _____

Child's First Language: _____
Child's Second Language: _____
Special Interests: _____
Siblings We Treat: _____

2) DENTAL HISTORY:

Is this your child's first visit to the dentist? ☐Yes ☐No
If not, how long since last dental visit? _____
Previous Dentist's Name: _____
Date of Last X-rays at Previous Dentist: _____
Have there been any injuries to the teeth, face or mouth? ☐Yes ☐No
If yes, please explain: _____
_____

Why did you bring your child to the dentist today:
_____
_____

Does your child have any of the following habits?
☐ Lip sucking/Biting ☐ Nail Biting
☐ Nursing/Bottle Habits ☐ Tobacco Use
☐ Thumb/Finger Sucking ☐ Pacifier Habit

Does your child have any current dental issues?
☐ Cavities ☐ Toothache
☐ Bleeding Gums ☐ Discolored Teeth
☐ Bad Breath ☐ Teeth Grinding
☐ Mouth/Tooth Trauma ☐ Sensitivity to Hot/Cold

Has your child ever had a serious problem associated with previous dentist? ☐Yes ☐No
If yes, please explain: _____
_____

Is your child's water fluoridated? ☐Yes ☐No
Is your child using fluoride toothpaste? ☐Yes ☐No
Has your child ever had any pain or tenderness in his/her jaw/joint? ☐Yes ☐No
Does your child brush teeth daily? ☐Yes ☐No
Does your child floss teeth daily? ☐Yes ☐No

3) HEALTH HISTORY:

Has your child ever had any of the following conditions?

☐ Abnormal Bleeding
☐ ADD/ADHD
☐ Allergies to Any Drugs
☐ Allergies to Latex
☐ Any Hospital Stays
☐ Any Operations
☐ Asthma
☐ Autism Spectrum Disorder
☐ Hemophilia/Bleeding Disorder
☐ Cardiac (Heart) Conditions
☐ Congenital Birth Defects
☐ Developmental Delays/ Disabilities
☐ Diabetes
☐ Hearing Impairment
☐ Cancer
☐ Hepatitis
☐ HIV+/AIDS
☐ Kidney/Liver Conditions
☐ Pregnancy
☐ Reflux/GI Problems
☐ Rheumatic/Scarlet Fever
☐ Seizures
☐ Tuberculosis
☐ **None of the Above**

If you checked any of the above conditions, or if you would like to discuss any other medical conditions please describe below:
_____
_____
_____

Child's Pediatrician: _____
Phone #: _____
Are immunizations up-to-date? ☐Yes ☐No
List all medications your child is currently taking:
_____
List all allergies: _____

PARENT SIGNATURE: _____ **DATE:** _____

DOCTOR SIGNATURE: _____ **DATE:** _____

UPDATE 1: ☐ No changes ☐ Changes: _____ Initials: _____ Date: _____
UPDATE 2: ☐ No changes ☐ Changes: _____ Initials: _____ Date: _____
UPDATE 3: ☐ No changes ☐ Changes: _____ Initials: _____ Date: _____