Vista Ridge Family Dentistry

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Child Registration Form

Child's name_____ Preferred to be called:_____ Sex:_____

D.O.B.:_____ Age:_____ Home Address:_____

City:_____ State:_____ Zip:_____ Phone Number:_____

Person Responsible For Account:_____

Mother
Name:_____

Home Phone:_____ Cell:_____

Email:_____

Employer:_____

Occupation:_____

SS#:_____

Father
Name:_____

Home Phone:_____ Cell:_____

Email:_____

Employer:_____

Occupation:_____

SS#:_____

Dental Insurance:_____

Patient's Physician:_____

Who can we thank for referring you to our office?_____

The following information is important for the patient's maximum safety, comfort, and optimum dental care. This information will be held in the utmost confidence by this office. Please yes/no to the following:

Is the patient presently under the care of a physician? Yes ◯ No ◯

Allergic Reaction to: Penicillin ◯ Latex ◯ Aspirin/Ibuprofen/Acetaminophen ◯ Metals ◯ Other:_____

Does the patient have any limited disabilities? Yes ◯ No ◯ If yes please list:_____

Has the patient ever had any of the following:

A)	Rheumatic Fever	◯ Yes ◯ No	G)	Asthma or Respiratory	◯ Yes ◯ No
B)	Rheumatic Heart Disease	◯ Yes ◯ No	H)	Diabetes	◯ Yes ◯ No
C)	Congenital Heart Disease	◯ Yes ◯ No	I)	Liver Trouble/Jaundice	◯ Yes ◯ No
D)	Blood Disorder	◯ Yes ◯ No	J)	Heart Murmur	◯ Yes ◯ No
E)	Epilepsy or Convulsions	◯ Yes ◯ No	K)	HIV/AIDS	◯ Yes ◯ No
F)	Snoring	◯ Yes ◯ No	L)	ADD/ADHD	◯ Yes ◯ No

Authorization and Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I certify that I have read the contents of this form and do realize the risks and limitations involved.

Signature of parent/guardian_____ Date_____