Child Registration

Southpointe Dental
James Lichtsinn, DDS

Childs Name: ______________________________ **Birthdate:** ___________________

Primary Address: ____

City: ___________________________________State:_____________ Zip: ___________

Best Contact Phone: ____________________ Text Confirmation? Yes / No - T-Mobile AT&T Verizon Sprint

Best Contact Email: ____

Whom may we thank for referring you? ____

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Parent/Guardian: _____________________________ Relationship to Patient: ☐Mother ☐Father ☐Guardian

Best Contact Phone: ___________________________ Text? Yes / No - T-Mobile AT&T Verizon Sprint

Parent/Guardian: _____________________________ Relationship to Patient: ☐Mother ☐Father ☐Guardian

Best Contact Phone: ___________________________ Text? Yes / No - T-Mobile AT&T Verizon Sprint

Person to notify in case of emergency: ____

Best Contact Phone: ___________________________ Text? Yes / No - T-Mobile AT&T Verizon Sprint

Person Responsible For Account:____

Address: *(if different from child)* ____

Responsible Party Employer: _______________________________ SSN # ___________________________

~PRIMARY INSURANCE~

Policy Holder Name: ____ DOB: ____________________

Employer: ____Occupation: ____________________________

Insurance Company: ____

Member ID / SSN: _________________________________ Group # _______________________________

~SECONDARY INSURANCE~

Policy Holder Name: ____ DOB: ____________________

Employer: ____Occupation: ____________________________

Insurance Company: ____

Member ID / SSN: _________________________________ Group # _______________________________

~DENTAL HISTORY~

Reason For Today's Visit: ____

Former Dentist: _____________________________________ Date of Last Dental Visit:________________

Brushing Frequency: _____ / Day **Floss Daily**? Yes / No

Any difficulty with dental visits? Yes / No Explain:____

Does your child have any oral habits? (Check all that apply)

☐Suck Thumb/Fingers ☐Pacifier ☐Chew Hard Objects (pencils, etc.) ☐Bite/Chew Nails ☐Grind Teeth ☐Snore

Any specific dental concerns that you would like us to address? ____
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Child Registration

Childs Name: _____ **Birthdate:** _____

~MEDICAL HISTORY~

Child's Physician/Clinic _____Phone: _____

Date of Last Wellness Check Up: _____

Is your child currently under physician care for anything other than wellness checkups? Yes No

(*If yes, describe*)_____

Smoke or Use Tobacco Products? ☐Yes ☐No

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Select All That Apply)

❑ Aspirin Allergy ❑ Codeine Allergy ❑ Erythromycin Allergy ❑ Food Allergy

❑ Hay Fever ❑ Penicillin Allergy ❑ Sulfa Allergy ❑ Other Allergies: _____

MEDICAL CONDITIONS - (Select All That Apply)

❑ AIDS / HIV+
❑ Anemia
❑ Asthma
❑ Blood Disease
❑ Behavior Issues
❑ Cancer
❑ Chicken Pox
❑ Cough, Persistent
❑ Diabetes
❑ Dizzy Spells/Fainting
❑ Eating Disorder
❑ Headaches
❑ Hearing Impaired
❑ Heart Problems
❑ Hepatitis
❑ Hemophilia / Abnormal Bleeding
❑ Kidney Disease/Trouble
❑ Liver Disease
❑ Psychiatric Care
❑ Respiratory Disease
❑ Rheumatic / Scarlet Fever
❑ Seizures
❑ Shortness of Breath
❑ Skin Rash
❑ Spina Bifida
❑ Thyroid Disease
❑ Tonsillitis
❑ Tuberculosis
❑ Other: _____
_____

Immunizations Current? ☐Yes ☐No

Medications your child is taking: _____

_____

Authorization and Release I authorize and request my insurance company to pay directly to Southpointe Dental any insurance benefits otherwise payable to me. I authorize Southpointe Dental to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

**By sharing my Cell Phone, Home Phone, Address, Work Phone and/or Email, I am giving Southpointe Dental permission to contact me via one of these methods to relay information concerning my appointments, treatment information, billing information and/or information about my dental health. If I do not wish to be contacted by one of these methods, I will advise Southpointe Dental. In addition, I authorize Southpointe Dental to use anonymous photos of my teeth for publications, web pages and other educational materials produced and representing Southpointe Dental without compensation to me.*

Signature of parent or guardian: _____ **Date:** _____