ANDREW R. GALL, DDS
Child Registration Form

CHILD INFORMATION:

Name_____
First name Middle initial Last name Preferred name

Street address_____

City, State, Zip code_____

Birth date_____ Age_____ Male_____ Female_____

PARENT INFORMATION:

Parent name_____

Parent's address if different from child's_____

Phone numbers:

Home_____Work_____Cell_____

Parent email address for appointment verification and reminders:

_____

Parent social security number_____Parent birth date_____

Employer_____

Employer's address_____

Occupation_____

Dental Insurance Information: (If applicable)

Employer who carries policy_____

Name of dental insurance company _____

Dental insurance company claim address_____

Group number for policy_____

Name of policyholder (parent)_____

Policyholder's social security number _____

Policyholder's birth date_____

In case of emergency, who should be notified?_____

Andrew R. Gall, DDS
Child Dental and Medical History

Dental history:

Date of last dental exam_____

Date of last dental x-rays_____

Has your child had difficulties associated with previous dental treatment?

If yes, explain_____

_____

Please indicate any of the items below that apply to your child:

____Injury to mouth or teeth
____Frequent ulcers or blisters
____Grinding of teeth
____Recurrent/frequent headaches
____Oral habits: thumb sucking, nail biting
____Sensitive/painful teeth
____Bleeding gums

Medical history:

Has your child had any of the following medical conditions:

____Heart murmur
____Diabetes
____Hepatitis/jaundice
____Asthma
____Cancer/tumors
____Mental handicap
____Hearing impairment
____Hyperactive
____Surgeries
____Premature birth
____Congenital heart disease
____HIV Virus/AIDS
____Convulsions/epilepsy
____Rheumatic fever
____Kidney/liver problems
____Physical handicap
____Speech impairment
____Hospitalization
____Tuberculosis

Explain any "Yes" answers above or other problems not listed:_____

_____

_____

List any drugs your child is now taking:_____

_____

List any drugs your child is allergic to:_____

_____

Child's physician_____

Signature of parent completing this form

_____

OFFICE USE ONLY Medical History Update:

_____

_____

_____