



TAYLOR POPE, DMD
CHILD REGISTRATION FORM

*The following information is necessary for proper treatment and understanding of your child.
Thank you for completing in full.*

Patient's Name: _____ Preferred Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Preferred Email: _____

Father's Name: _____ Social Sec.#: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Where Employed: _____ Business Phone #: _____

Home Phone #: _____ Cell #: _____ Preferred # for Courtesy/Confirmation Call: _____

Mother's Name: _____ Social Sec. #: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Where Employed: _____ Business Phone #: _____

Home Phone #: _____ Cell #: _____ Preferred # for Courtesy/Confirmation Call: _____

With whom does patient live? _____

Other children in family names & ages: _____

Person Responsible for this Account: _____ Relationship to Patient: _____

Dental Insurance: Yes _____ No. _____ Insurance Co.: _____ Policy #: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Emergency Contact: _____

Address: _____

Home Phone #: _____ Relationship to Patient: _____

Insurance: Your dental insurance contract is between you and your insurance company. We will help you obtain benefits by preparing necessary insurance reports. All professional services rendered are charged directly to the patient. Patients are responsible for payment of fees. I accept responsibility for the payment of this account for all services rendered. I understand that all delinquent accounts are turned over to a collection agency and that patients are responsible for the balance of their account and all associated collection fees.

Consent for Treatment: I hereby agree to diagnostic procedures, dental treatments, and methods as found necessary by Dr. Pope for the restoration and maintenance of my dental health.

Release of Information: I authorize release of this information to medical doctor or record, and to my insurance company as needed for filing of my claims. I understand treatment plans and fees presented could change depending upon the extent of dental disease and the time elapsed since the initial examination.

Signature of Parent or Legal Guardian: _____ Date: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name: _____ Office Telephone #: _____

Is your child in good health? Yes No

Does your child have regular medical exams? Yes No

Is your child up to date with immunizations? Yes No

Is your child taking any medication? Yes No

If yes, what? _____

Is your child allergic to any medication? Yes No

If yes, what? _____

Is your child undergoing medical treatment? Yes No

If yes, what? _____

Has your child been hospitalized other than at birth? Yes No

Date: _____ Reason: _____

Is this your child's first dental visit? Yes No

Does your child have a toothache? Yes No

Purpose of this appointment: _____

Please list any prescriptions and/or over the counter medications your child is currently taking: _____

Does your child have any of the following?

ADHD Yes No

Allergies Yes No

Asthma Yes No

Autism Yes No

Bleeding Disorder Yes No

Blood Disorder Yes No

Brain Injury Yes No

Cerebral Palsy Yes No

Diabetes Yes No

Emotional Disorder Yes No

Epilepsy Yes No

Hepatitis Yes No

Hearing Disorder Yes No

Heart Condition Yes No

Heart Murmur Yes No

Kidney Problem Yes No

Liver Problem Yes No

Lung Problem Yes No

Mental Disorder Yes No

Nervous Disorder Yes No

Physical Disorder Yes No

Sickle Cell Anemia Yes No

Speech Disorder Yes No

Tuberculosis Yes No

Vision Disorder Yes No

Other _____

Does your child use any of the following:

Pacifier Yes No Aged Stopped: _____

Sippy Cup Yes No Aged Stopped: _____

Bottle Yes No Aged Stopped: _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment below:
