Magic Smiles

Dentistry for Children & Young Adults

Victoria Sullivan, DDS

916-941-2341
530-677-6222
5009 Windplay Dr., Ste. 1
El Dorado Hills, CA 95762

CHILD REGISTRATION FORM

Please Complete Each Section In Full

CHILD

FIRST NAME_____ LAST NAME _____ MIDDLE INITIAL_____

PREFERRED NAME_____AGE_____BIRTHDATE_____

SCHOOL_____GRADE_____

WHAT IS CHILD'S FAVORITE:

SPORT_____TOY_____HOBBY_____PERSON_____FICTIONAL CHARACTER_____

MOTHER

FIRST NAME_____ LAST NAME _____ MIDDLE INITIAL_____

ADDRESS_____ ADDRESS 2 _____

CITY, STATE, ZIP _____ EMAIL_____

HOME PHONE_____ WORK PHONE _____ CELL_____

BIRTHDATE_____ SOCIAL SECURITY #_____ DRIVERS LIC_____

☐RESPONSIBLE PARTY ☐PRIMARY INSURANCE POLICY HOLDER ☐SECONDARY INSURANCE POLICY HOLDER

FATHER

FIRST NAME_____ LAST NAME _____ MIDDLE INITIAL_____

ADDRESS_____ ADDRESS 2 _____

CITY, STATE, ZIP _____ EMAIL_____

HOME PHONE_____ WORK PHONE _____ CELL_____

BIRTHDATE_____ SOCIAL SECURITY #_____ DRIVERS LIC_____

☐RESPONSIBLE PARTY ☐PRIMARY INSURANCE POLICY HOLDER ☐SECONDARY INSURANCE POLICY HOLDER

PRIMARY INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT: ☐MOTHER ☐FATHER ☐OTHER

INSURED SOCIAL SECURITY #_____INSURED BIRTHDATE_____

EMPLOYER_____ INS COMPANY _____

ADDRESS_____ ADDRESS _____

ADDRESS 2 _____ ADDRESS 2 _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT: ☐MOTHER ☐FATHER ☐OTHER

INSURED SOCIAL SECURITY #_____INSURED BIRTHDATE_____

EMPLOYER_____ INS COMPANY _____

ADDRESS_____ ADDRESS _____

ADDRESS 2 _____ ADDRESS 2 _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

CAN ANYONE ELSE AUTHORIZE TREATMENT ☐YES ☐NO (IF YES, LETTER MUST BE ON FILE)

WHO IS FINANCIALLY RESPONSIBLE_____

Dental History

Magic Smiles
Dentistry for Children & Young Adults

Victoria Sullivan, DDS

916-941-2341
530-677-6222
5009 Windplay Dr., Ste. 1
El Dorado Hills, CA 95762

CHILD HISTORY FORM

CHILDS
FIRST NAME_____

LAST NAME _____

Please Complete Each Section In Full

DATE OF LAST VISIT TO A DENTIST _____

FOR WHAT SERVICE _____

HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS? ☐YES ☐NO

COMPLAINTS _____

ANY UNHAPPY DENTAL EXPERIENCES? ☐YES ☐NO

DESCRIBE _____

ANY INJURIES TO MOUTH - TEETH - HEAD? ☐YES ☐NO

DESCRIBE _____

ANY MOUTH HABITS - THUMBSUCKING - NAIL BITING - MOUTH BREATHING- NURSING BOTTLE HABITS - PACIFIER - ETC. ☐YES ☐NO

DESCRIBE _____

ANY UNUSUAL SPEECH HABITS? ☐YES ☐NO DESCRIBE _____

ANY LOST TEETH? ☐YES ☐NO DESCRIBE _____

HAVE MISSING TEETH BEEN REPLACED? ☐YES ☐NO BY WHOM _____

ORTHODONTIC APPLIANCES WORN NOW OR EVER? ☐YES ☐NO

DOES YOUR CHILD BRUSH THEIR TEETH DAILY? ☐YES ☐NO DO YOU ASSIST YOUR CHILD WITH TOOTH BRUSHING? ☐YES ☐NO

HOW OFTEN DO THEY BRUSH? _____

IS DENTAL FLOSS USED? ☐YES ☐NO HOW OFTEN? _____ ARE DISCOLORING TABLETS USED? ☐YES ☐NO

IS FLUORIDE TAKEN IN ANY FORM? ☐YES ☐NO HOW? _____

DO YOU DESIRE COMPLETE DENTAL SERVICES FOR THIS CHILD? ☐YES ☐NO

CHILD'S ATTITUDE TO DENTISTRY _____

MAY WE REQUEST YOUR CHILD'S MEDICAL RECORDS FOR OUR REFERENCE IF NECESSARY ? ☐YES ☐NO

THIS INFORMATION WAS DISCUSSED
WITH AND GIVEN BY (PRINT NAME): _____

RELATION TO CHILD _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in the child's health or medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Please Complete Each Section In Full

Medical History

CHILD'S NAME_____

CHILD'S PHYSICIAN_____

ADDRESS_____

PHONE_____ DATE OF LAST PHYSICAL EXAM_____

RESULTS_____

IS CHILD UNDER CARE OF PHYSICIAN NOW FOR ANY OTHER CONDITION? ☐YES ☐NO PHYSICIAN'S NAME_____

DOES CHILD TAKE ANY MEDICATION NOW? ☐YES ☐NO PLEASE LIST _____

DOES CHILD HAVE GOOD PHYSICAL COORDINATION? ☐YES ☐NO

DOES CHILD HAVE ANY EMOTIONAL PROBLEMS _____

_____

ALLERGIES ☐YES ☐NO:

☐YES ☐NO FOODS_____ ☐YES ☐NO ANIMALS_____

☐YES ☐NO POLLEN _____ ☐YES ☐NO OTHER (PLEASE LIST)_____

☐YES ☐NO MEDICATIONS_____

PENICILLIN _____ OTHER_____

Has child any history of or difficulty with any of the following: ☐YES ☐NO (IF YES PLEASE MARK EACH THAT APPLIES)

☐ ADD/ADHD	☐ CONVULSIONS	☐ HYPERACTIVITY	☐ PREGNANT/NURSING
☐ ALLERGY TO LATEX	☐ DIABETES	☐ JAW PROBLEMS	☐ PSYCHIATRIC DISORDER
☐ ANEMIA	☐ EPILEPSY	☐ KIDNEY	☐ RHEUMATIC FEVER
☐ ASTHMA	☐ EYE PROBLEMS	☐ HEARING	☐ SCARLET FEVER
☐ AUTISM	☐ FAINTING	☐ LEUKEMIA	☐ SICKLE CELL ANEMIA
☐ BLADDER	☐ HEARING	☐ LIVER	☐ SCOLIOSIS
☐ CANCER	☐ HEART	☐ MEASLES	☐ SORE THROATS (FREQUENT)
☐ CEREBRAL PALSY	☐ HEPATITIS - TYPE___	☐ MENTAL RETARDATION	☐ SPEECH THERAPY
☐ CHICKEN POX	☐ HEMOPHILIA	☐ MONONUCLEOSIS	☐ TETANUS
☐ CHRONIC SINUS	☐ HIV	☐ MUMPS	☐ THYROID

HAS CHILD EVER HAD SURGERY? ☐YES ☐NO PLEASE DESCRIBE_____

_____

HAS CHILD EVER BEEN HOSPITALIZED? ☐YES ☐NO PLEASE DESCRIBE_____

_____

DOES CHILD HAVE EXCESSIVE BLEEDING WHEN CUT? ☐YES ☐NO

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES, OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED:

_____

_____

_____