

PEDIATRIC
REGISTRATION FORM



fremont dental

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For office use only:

Chart #: _____

Provider: _____

Patient Name: _____ Sex: M F
First Middle Last

Patient's Preferred Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email Address: _____

Who may we thank for referring you to our practice? _____

School: _____ Grade: _____ Age: _____

MOTHER/GUARDIAN INFORMATION:

Name: _____ SS#: _____ Birthdate: _____

Employer: _____ Position: _____ Work Phone #: _____

FATHER/GUARDIAN INFORMATION:

Name: _____ SS#: _____ Birthdate: _____

Employer: _____ Position: _____ Work Phone #: _____

Person financially responsible for payment (Check one): Mother Father Other _____

Address (if different than above): _____ City: _____ State: _____ Zip Code: _____

Phone number: _____

Dental Insurance (please circle): Yes No Name of Insurance Company: _____

Policy Holder's Name: _____ Group #: _____

DENTAL HISTORY

____ Yes ____ No Has your child ever been to a dentist? Name of the dentist and dates _____

____ Yes ____ No Has your child experienced any unfavorable reaction from previous dental care? (please explain) _____

____ Yes ____ No Does your child suck a finger, thumb, or pacifier? (Please check the appropriate habit) _____

FOR CHILDREN UNDER 6 YEARS OLD

Was your child _____ breast fed _____ bottle fed? Until what age? _____

I request and authorize the dentist to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental radiographs as may be considered necessary by the dentist to diagnose and/or treat my child's dental problem. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand that treatment in terms appropriate for their age. The dentist will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for treatment. In the event that Fremont Dental seeks enforcement of this agreement through the services of a collection agency, I shall be responsible for any incidental expenses including all collection costs and reasonable attorney fees.

Signature of Parent/Guardian: _____ Date: _____

