Welcome to Braden Dental Center... Two Generations of Professional Care.

CHILD REGISTRATION & HISTORY

We at Braden Dental Center appreciate your confidence in us, and we pledge to provide your child with the finest in dental care. Please fill out this form carefully and completely. The more accurate the information and better we know your child, the better we can care for him or her. We think that's important!

Mark T. Braden, D.D.S.

Ryan T. Braden, D.D.S.

Braden Dental Center is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

CHILD REGISTRATION & HISTORY

ABOUT YOUR CHILD AND YOU

Child's Name: ______________________________
Last First Middle Initial

Nickname: ______________________________

Home Address: ______________________________
Street / P.O. Box

____
City State Zip Code

Mailing Address, if Different:

____
Street / P.O. Box

____
City State Zip Code

Father's Name: ______________________________

Social Security #: ______________________________

Father's Birthday: ______________________________
Month Day Year

Father's Employer: ______________________________

Occupation: ______________ How Long Held: ________

Employer Address: ______________________________
Street P.O. Box

____
City State Zip Code

Business Phone: ______________________________

Mother's Name: ______________________________

Social Security #: ______________________________

Mother's Birthday: ______________________________
Month Day Year

Mother's Employer: ______________________________

Occupation: ______________ How Long Held: ________

Employer Address: ______________________________
Street P.O. Box

____
City State Zip Code

Business Phone: ______________________________

Person Financially Responsible (if other than parent):

____

Relationship to Child: __________ Home Phone: __________

Address: ______________________________
Street / P.O. Box

____
City State Zip Code

What is your child's favorite Sport: ______________

Toy: ______________ Hobby: ______________

Person: ______________ Fictional Character: ______________

Who referred you to us today? ______________

CONTACT INFORMATION

Home Phone: ______________________________

Parent's Work Phone: ______________________________

Cell Phone: ______________________________

E-Mail: ______________________________

When is the best time to reach you? ______________

Where? ______________________________

In an emergency, who could we contact?

Name: ______________________________

Relationship: ______________________________

Work Phone: ______________ Home Phone: ______________

DENTAL INSURANCE

Do you have dental insurance through your employer?

❑ Yes ❑ No

If yes, please provide the following information:

Dental Insurance Co. #1: ______________________________

Group #: ______________ Ins. Co. Phone: ______________

Member ID #: ______________________________

Ins. Co. Address: ______________________________
City State Zip Code

Do you have any other Dental Insurance Coverage?

❑ Yes ❑ No

This coverage is through: ❑ Spouse ❑ Parent

❑ Other: ______________________________

Their Name: ______________________________

Their Employer's Name & Address: ______________

____

Their Social Security #: ______________________________

Their Birthdate: ______________________________
Month Day Year

Dental Insurance Co. #2: ______________________________

Group #: ______________ Ins. Co. Phone: ______________

Member ID #: ______________________________

Ins. Co. Address: ______________________________
City State Zip Code

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process my claims.

Signature ______________________ Date __________

ASSIGNMENT OF BENEFITS

I authorize payment directly to Braden Dental Center of group insurance benefits otherwise payable to me.

Signature ______________________ Date __________

MEDICAL HISTORY

Although the staff at Braden Dental Center primarily treats the area in and around your child's mouth, the mouth is a part of the entire body. Health problems your child may have, or medications he/she may be taking, can have an important relationship with the dentistry your child will receive. Thank you for answering the following medical questions.

Child's Physician: ______________________

Address: ______________________

Phone: ______________________

Approximate date of last physical exam: ______________________

Is your child currently under the care of a physician?

❑ Yes ❑ No If yes, please explain: ______________________

Is your child now receiving any drugs prescribed by a physician or dentist?

❑ Yes ❑ No If yes, please list: ______________________

Does your child experience excessive bleeding when cut?

❑ Yes ❑ No If yes, please describe: ______________________

Has your child ever been hospitalized or had a major operation?

❑ Yes ❑ No If yes, please describe: ______________________

Has your child ever had a serious head or neck injury?

❑ Yes ❑ No If yes, please describe: ______________________

Does your child have any emotional problems?

❑ Yes ❑ No If yes, please describe: ______________________

Does your child have any history of or difficulty with any of the following?

- ❑ AIDS HIV+
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Artificial Heart Valve*
- ❑ Asthma
- ❑ Bladder Problem
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruising Easily
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Chemotherapy
- ❑ Chicken Pox
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Chronic Sinus
- ❑ Diabetes
- ❑ Easily Winded
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent/Severe Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Hearing Problems
- ❑ Heart Murmur*
- ❑ Heart Surgery
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ High Blood Pressure
- ❑ Hives/Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mastoid
- ❑ Measles
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Renal Dialysis
- ❑ Rheumatic Fever*
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Ulcers
- ❑ Yellow Jaundice

OFFICE USE ONLY
Doctor's Comments:

____

*Condition may require medication.

Has your child ever had any serious illness or medical conditions not listed above?

❑ Yes ❑ No

If yes, describe: ______________________

BRADEN
DENTAL CENTER

Is your child allergic to any of the following?

❑ Acrylic ❑ Animals ❑ Aspirin ❑ Codeine

❑ Dental Anesthetics ❑ Dust ❑ Erythromycin

❑ Food ❑ Latex ❑ Metal ❑ Penicillin ❑ Pollen

❑ Tetracycline ❑ Other

If other, please list: ____________________

DENTAL HISTORY

Why have you brought your child to Braden Dental Center today?

____

Date of last dental visit: ____________________

For what service?____________________

Has your child ever complained about dental problems?

❑ Yes ❑ No If yes, describe: ____________________

____

Has your child ever had any unhappy dental experiences?

❑ Yes ❑ No If yes, describe: ____________________

____

Has your child had any injuries to the mouth, teeth or head?

❑ Yes ❑ No If yes, describe: ____________________

____

Does your child have any lost teeth?

❑ Yes ❑ No

Have missing teeth been replaced?

❑ Yes ❑ No

Has your child had any mouth habits—thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.?

❑ Yes ❑ No If yes, please describe: ____________________

____

Have orthodontic appliances been worn, now or ever?

❑ Yes ❑ No If yes, please describe: ____________________

____

Please describe your child's attitude toward dentistry:

____

____

____

Does your child brush his/her teeth daily?

❑ Yes ❑ No

Do you assist your child with tooth brushing?

❑ Yes ❑ No If yes, how often?____________________

Is dental floss used?

❑ Yes ❑ No

Are disclosing tablets used?

❑ Yes ❑ No

Has fluoride been taken in any form?

❑ Yes ❑ No

Any other comments or additional information you think we should know about your child?

____

____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform Braden Dental Center of any changes in my child's medical status.

____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form carefully and completely. It will allow us to treat your child more effectively and to provide the latest and best in dental care. If you have any questions at any time, please don't hesitate to ask!

BRADEN
DENTAL CENTER

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