Zachary J. Lester, D.M.D.
COMPREHENSIVE FAMILY DENTISTRY

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Child Registration Form

____ / ____ / ____
Date

_____ ____ / ____ / ____ ☐ Male ☐ Female
Child's Name (last, first, m.) Date of Birth

____ - ____ - ____ _____ _____
Child's SSN Guardian's Name Relation to Child

☐ Home ☐ Work ☐ Cell (____) _____ (____) _____
Indicate the best number to reach you at with a ✓

_____
Email

_____ _____ ____ _____
Mailing Address City State Zip

_____ _____
Child's School Child's Interest/Hobbies

_____
How did you hear about your office?

_____ _____
Person responsible for the account Relation to child

☐ Home ☐ Work ☐ Cell (____) _____ _____
Indicate the best number to reach you at with a ✓ Email

_____ _____ ____ _____
Mailing Address City State Zip

DENTAL INSURANCE INFORMATION

_____ _____
Primary Insurance Coverage Secondary Insurance Coverage

_____ _____
Employer Name Employer Name

_____ _____
Subscriber's Name & Date of Birth Subscriber's Name & Date of Birth

_____ _____
Subscriber's SSN or ID Subscriber's SSN or ID

_____ _____
Group # Group #

Child's Name (last, first, m.) _____ / _____ / _____ Date of Birth

HEALTH QUESTIONNAIRE

There are many medical situations which can affect or be affected by the procedures or drugs used in dentistry. Therefore, please fill out the following information VERY carefully. Thank you.

Are you presently ill or under the care of a physician? ☐ Yes ☐ No _____ If yes, please describe

_____ / _____ / _____ Date of last MEDICAL exam _____ Physician's Name

Do you have, or have you had: (Please check at the RIGHT of each item)

(Check each item)	Yes	No	Don't Know	(Check each item)	Yes	No	Don't Know	(Check each item)	Yes	No	Don't Know
Allergies (medications, other)				Heart murmur				Hepatitis (indicate type):			
If yes, please list here:				Heart problems				Psychiatric/Emotional problems			
				Asthma				Epilepsy or Seizures			
Diabetes (indicate type):				Sinus problems				Fainting or Dizziness			
Rheumatic fever				Bruise or bleed easily							

Describe any current medical treatment or physical conditions our doctors should be aware of.

Describe any current medications, conditions or medical treatment not listed above (including aspirin, vitamins, etc).

Does your child take a fluoride tablet, fluoride drops or live in an area with a fluoridated water system?

DENTAL QUESTIONNAIRE:

Do you have any of the following? Indicate with a ✓

- ☐ Concerns w/ appearance of teeth
- ☐ Teeth sensitive to cold, hot, sweets or pressure
- ☐ Bleeding gums
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Removable dental appliance
- ☐ Swelling or lumps in mouth
- ☐ Unpleasant taste
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Unpleasant dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Bad breath
- ☐ Snoring or problems sleeping
- ☐ Other

_____ / _____ / _____ Date of last dental exam _____ Any previous dental treatment? _____ / _____ / _____ When

Are there any dental concerns at this time?

I acknowledge that I am responsible for the accuracy of the above information. I will notify my dentist if there is a change to any of my health and dental history, medications, allergies, contact information and insurance information. I hereby certify that the above information is true and correct to the best of my knowledge.

_____ Signature (Patient or Parent/Guardian if Under 18) _____ / _____ / _____ Date