Brea Schmidt, DDS
14 East 4th Street Spencer, IA 51301
(712) 580-3300

Child's Registration and Health History

PLEASE PRINT

Date

Child's Information

Child Last Name, First Name, MI			Nickname	Social Security #
Address				
City		State		Zip
Home Telephone	Cell Phone	Date of Birth	Age	Gender ☐Male☐Female

Parent's Information

Mother's Name	Circle One Mother/Stepmother/Guardian	Date of Birth	Home Phone
Address			Social Security #
Employer			Work Phone
Father's Name	Circle One Father/Stepfather/Guardian	Date of Birth	Home Phone
Address			Social Security #
Employer			Work Phone

Who is responsible for this account? _____

Who is accompanying the child today? _____

Do you have legal custody of this child? _____

How did you hear about us? _____

Names and ages of other children in the family: _____

Emergency Contact (Other Than Parents)

Last Name, First Name, MI	Phone

DENTAL INSURANCE INFORMATION

PRIMARY

Insurance Co. Name		Member Benefits Phone Number
Address (to send claims)		
City	**State**	**Zip**
Policy Owner's Name	**Relationship to Patient**	**Group #.**
Policy Owner's Employer	**Policy Owner's SS#**	Policy Owner's Birth Date

SECONDARY DENTAL INSURANCE

Insurance Co. Name		Member Benefits Phone Number
Address (to send claims)		
City	**State**	**Zip**
Policy Owner's Name	**Relationship to Patient**	**Group #.**
Policy Owner's Employer	**Policy Owner's SS#**	Policy Owner's Birth Date

HAVE YOUR CHILD EVER BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING PROBLEMS?	**NO**	**YES (If Yes, Please Explain)**
Abnormal Bleeding		
ADHD/ADD/ODD		
Allergies to any Drugs/Medical Materials (ex. Latex)		
Any Hospital Stays Overnight		
Any Operations		
Asthma		
Autism		
Blood Transfusion		
Cancer/Tumors		
Cerebral Palsy		
Congenital Heart Disease		
Convulsions/Epilepsy		
Diabetes		
Hearing Impairment		
Heart Murmur		
Hemophilia		
Hepatitis		
HIV+/AIDS		
Kidney/Liver Problems		
Mental Retardation		

List any medications that your child is allergic to:_____

List any medication your child is currently taking:_____

Any other disease, illness, past surgeries, or health concerns?

_____

CHILD'S PRIMARY CARE PHYSICIAN

Name	**Phone**
Address	**Fax**

DENTAL HISTORY

Is this your child's first dental visit? _____

If not, who was their previous dentist? _____

How long since the last dental visit? _____

Were any x-rays taken at previous dental visits? _____

Has your child ever had an unpleasant dental experience? If yes, please explain. _____

_____

Has your child ever received injuries to the teeth, face, or mouth? If yes, please explain. _____

_____

Does your child have a thumb, finger, or pacifier habit?_____

Does your child use a nursing bottle or sippy cup? _____

How often does your child brush? _____ times per day

How often does your child floss? _____ times per week

Does your child receive help brushing and flossing? _____

Does your child drink city water? _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize Dr. Schmidt and her staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Schmidt to diagnose and/or treat my child's dental problems. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes.

_____ _____

Signature of Parent or Guardian Date