Kvinsland
Dentistry
a harbor tradition

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Child Registration

Date: _____ Referred by: _____

Child's name: _____
(first, middle, last)

Nickname: _____ Birth date: _____

Parent's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

School: _____

Person responsible for the account: _____

Insurance Information

Primary Insurance: _____

Subscriber: _____ Employer: _____

SS# _____ Date of Birth: _____

Secondary Insurance: _____

Subscriber: _____ Employer: _____

SS# _____ Date of Birth: _____

Information for Emergency Treatment

Date of last dental examination?_____

Are there any dental concerns at this time? _____

Date of last medical examination? _____

Does child have or has child ever had and of the following?	YES	NO
Anemia	_____	_____
Diabetes	_____	_____
Hepatitis	_____	_____
Allergies	_____	_____
To penicillin	_____	_____
To local anesthetic	_____	_____
Abnormal heart condition	_____	_____
Abnormal bleeding from a cut	_____	_____
Rheumatic fever	_____	_____
Heart Murmur	_____	_____
Is your child under the care of a physician now?	_____	_____
Is any medication being taken now?	_____	_____

If “yes”, please list: _____

Any other physical conditions we should be aware of? _____

_____

_____

Name of physician: _____

Telephone #: _____

Information given by (signature): _____