Frisco Dental LLC
Molly Smith, DMD, MS

Welcome to Frisco Dental

Child Registration

Patient:_____ Date:_____
Mailing Address: _____
Physical Address: _____
Home Phone: _____ Parent Cell Phone:_____
Age: _____ Date of Birth: _____ Sex: _____
Social Security Number: _____

Responsible Party

Parent/Guardian: _____
Social Security Number: _____ Date of Birth: _____
Employer: _____ Occupation: _____
Business Address: _____ Phone: _____
Dental Insurance: _____ Group #: _____ ID: _____
In case of emergency, whom should we notify? _____
Phone: _____ Relationship to Patient: _____

Health & Dental History

Date of last dental visit: _____ Reason for today's visit: _____
Physician: _____ Date of last visit to physician: _____
Current Medications: _____ Allergies: _____
Hospitalizations: _____ Illness or Surgery: _____
History of negative medical or dental experiences?_____

Please circle yes or no for the conditions below referring to the patient. Please inform us if your child experiences a severe illness, hospitalization, or begins new medication.

Heart trouble	No	Yes	Rheumatic Fever	No	Yes
Allergy to penicillin	No	Yes	Bleeding or Clotting problems	No	Yes
Jaundice, Liver Disease	No	Yes	Asthma	No	Yes
Seizures	No	Yes	Behavioral Problem	No	Yes
Sleep with bottle at night/naps?	No	Yes	Any tooth pain?	No	Yes
Hearing or vision difficulties	No	Yes	Other		

Signature of Parent/Guardian: _____ Date: _____