

# REGISTRATION HISTORY - CHILD

**WILLIAM W. BABINGTON, D.D.S.**  
**DAVID T. BABINGTON, D.D.S.**

Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Grade \_\_\_\_\_ Interest & Hobbies \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone (F) \_\_\_\_\_ (M) \_\_\_\_\_

Father's Name (& address if different from child) \_\_\_\_\_

Father Employed By: \_\_\_\_\_ Position \_\_\_\_\_

Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name (& address if different from child) \_\_\_\_\_

Mother Employed By \_\_\_\_\_ Position \_\_\_\_\_

Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

In Case of Emergency, Who Should Be Notified \_\_\_\_\_ Phone \_\_\_\_\_

Who Will Pay This Account If Other Than Parent? \_\_\_\_\_

Dental Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_ ID# \_\_\_\_\_

Dental Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Relationship to Subscriber  Child  Other

Does child have, has child ever had:

	Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Allergies To:	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding From A Cut	<input type="checkbox"/>	<input type="checkbox"/>
- Penicillin,	<input type="checkbox"/>	<input type="checkbox"/>			
- Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>			
- Medications or Drugs	<input type="checkbox"/>	<input type="checkbox"/>			

If allergies to medications or drugs, indicate which ones \_\_\_\_\_

Is child taking any medication? \_\_\_\_\_ If so, for what? \_\_\_\_\_

Is child receiving other health care now? \_\_\_\_\_ If so, nature of care \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Does child use tobacco products of any kind? \_\_\_\_\_ What? \_\_\_\_\_

Has child seen an Orthodontist? \_\_\_\_\_ If locally, name \_\_\_\_\_

When was the last time child visited a dentist? \_\_\_\_\_

Other Children in Family (names & ages) \_\_\_\_\_

Whom may we thank for referring your child? \_\_\_\_\_

Comments: \_\_\_\_\_

This information is considered confidential and was given by \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_