Recall Registration Form

Child's Information

Child's First Name: _____ Last Name: _____ Date of Birth: ____/____/____
Age: _____ Gender: ❑Male ❑Female
Address: _____ City: _____ Zip: _____

Parent / Legal Guardian Information

First Name: _____ Last Name: _____
Cell #: _____ Work #: _____ Email: _____
Emergency Contact Name: _____ **Phone #**: _____

If anyone other than above will bring the child to their dental appointment, please include their name below. Please note – child will NOT be seen if name is not included here unless a notarized form is provided from parent/Legal guardian!!
Name: _____ Relationship: _____

Medical History

Please check box ☑ if patient has or ever has had one of the following conditions:

❑ ADHD	❑ Cystic Fibrosis	❑ Fainting/Dizziness	❑ Nutritional Disorder
❑ Asthma	❑ Diabetes	❑ Hearing Disorders	❑ Prolonged Bleeding
❑ Autistic	❑ Developmental Delay	❑ Heart Disease/Murmur	❑ Rheumatic Fever
❑ Blood Disorders	❑ Downs Syndrome	❑ Hepatitis	❑ Sickle Cell Disease
❑ Bone Disorders	❑ Ear Infections	❑ HIV / AIDS	❑ Speech disorders
❑ Cancer	❑ Epilepsy/Seizures	❑ Liver /Kidney Disorders	❑ Tuberculosis
❑ Cerebral Palsy	❑ Endocrine Disorders	❑ Mental Disorders	❑ Thyroid Issues

❑ Other _____

My child does not have any of the above health conditions ❑

Does Patient need antibiotics prophylaxis prior to dental treatment? ❑Yes ❑No

Does Patient have allergies?	**❑Yes**	**❑No**
Penicillin or any other antibiotic	❑Yes	❑No
Latex	❑Yes	❑No
Local Anesthetic	❑Yes	❑No
Other: _____		

Taking any medications? ❑Yes ❑No
What medications? _____
_____
_____

Authorization and Release

I certify the above information to be true to the best of my knowledge. I also understand that providing incorrect information is dangerous and I agree to inform the office of any changes in my child's health. I authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, administration of local anesthetic and fluoride which have been deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I certify that my child is covered by dental insurance. I understand that Sunkidz Pediatric Dentistry Group will file the claim for dental treatment completed on my child on my behalf. I acknowledge that I will be financially responsible for dental treatment not covered by my childs insurance.

Signature: _____ **Relationship** _____ **Date** _____