Pediatric Dental Care of Wilmington

213 Main Street, Wilmington, MA 01887 Phone: 978-694-4100

CHILD'S REGISTRATION AND HISTORY

Child's Name: ____ Preferred Name: _______________
First Middle Last
Gender: ☐ Male ☐ Female Birthday: _____________ Age: ___ School: ____________________________ Grade: ___
Have any other children in your family been a patient in this office before? If yes, name(s) _________________________
Is this your child's first dental visit? ☐ Yes ☐ No
If no, name of previous dentist: ____________________ Date of last visit: ______________ Purpose: _____________
Reason for today's visit: __________________________ Does your child have any dental pain today? ☐ Yes ☐ No
Has your child had any bad past dental experiences? ☐ Yes ☐ No If yes, please explain: ___________________________
Names and ages of siblings: ____
Name of child's pet: ________________ Favorite interest: __________________ Favorite sport: __________________
Name of parents' dentist: ____
Whom may we thank for referring you to our office? ____

GENERAL INFORMATION

Mother and father of child: ☐ Married ☐ Separated ☐ Divorced

Mother's Full Name: ____________________________
Relationship: ☐ Mother ☐ Stepmother ☐ Legal Guardian
Home Address: _________________________________
City: ____________________ State: ____ Zip: ________
Home Phone: _____________ Cell Phone: ___________
Email: ____
S.S. # __________________ Birthday: ______________
Occupation: ____________________________________
Employer: ______________________________________
Work Address: __________________________________
Work Phone: ____________________________________

Father's Full Name: ____________________________
Relationship: ☐ Father ☐ Stepfather ☐ Legal Guardian
Home Address: _________________________________
City: ____________________ State: ____ Zip: ________
Home Phone: _____________ Cell Phone: ___________
Email: ____
S.S. # __________________ Birthday: ______________
Occupation: ____________________________________
Employer: ______________________________________
Work Address: __________________________________
Work Phone: ____________________________________

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other
Who is responsible for making appointments? ____________________ What is the best time to call? ________________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: _________________________
Subscriber's Name: _____________________________
Relationship to Child: ____________________________
Group #: ______________________________________
Policy #: ______________________________________
Employer Name: _________________________________
How long have you had this coverage? _______________

Secondary Dental Insurance: _______________________
Subscriber's Name: _____________________________
Relationship to Child: ____________________________
Group #: ______________________________________
Policy #: ______________________________________
Employer Name: _________________________________
How long have you had this coverage? _______________

Who is responsible for the account? ____

I understand I am responsible for communicating any changes in address and/or insurance coverage to Pediatric Dental Care of Wilmington.

Signature of Parent or Guardian: ______________________________________ Date: ________________________