Kirby-Cochran Center for Dental Health, LLC
416 Martling Rd. • Albertville, AL 35951

CHILD REGISTRATION FORM

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Home Address: _____
Sex: _____ Age: _____ Birth Date: _____ Name of school attending: _____
Social Security Number: _____
Name of Father: _____ Name of Mother: _____
Please name members of immediate family: _____
Phone (Home): _____ Best time to call: _____
Nearest Relative: _____
Address: _____ Phone: _____
Preferred appointment times: ☐Morning ☐Afternoon ☐Evening ☐Any Time ☐M ☐Tu ☐W ☐Th ☐F ☐S

Health Information

Previous Dentist: _____ Date of last dental visit: _____
Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Mitral Valve Prolapse
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due Date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

Please list all medications you are now taking: _____

- Have you ever had any complications following dental treatment? ☐Yes ☐No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐Yes ☐No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐Yes ☐No
  If yes, please explain: _____

Whom may we thank for referring you to our practice? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent, or guardian: _____ Date: _____