

# MINOR/CHILD REGISTRATION

(PLEASE PRINT)

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Phone \_\_\_\_\_

## PATIENT INFORMATION

Date \_\_\_\_\_

Name of Minor/Child _____			
Last Name		First Name	
Initial			
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____	Birthdate _____	Nickname _____
Hobbies _____			
Home Address _____			
Street		City	State Zip
Mailing Address _____			
Street		City	State Zip
Person financially responsible _____		Home Phone _____	Work Phone _____
Whom may we thank for referring you? _____			

## INSURANCE

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone _____ Work Phone _____ (if different from above) (if different from above)	Home Phone _____ Work Phone _____ (if different from above) (if different from above)
Employer _____	Employer _____
Soc. Sec.# _____ Birthdate _____	Soc. Sec.# _____ Birthdate _____
Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____	Plan Name _____
Phone No. _____	Phone No. _____
Address _____	Address _____
Group# _____	Group# _____
Policy# _____	Policy# _____
Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's Medical Assistance Identification# _____

## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

## DENTAL HISTORY

Date of last visit to a dentist _____	For what service _____		
Has child complained about dental problems? _____	YES <input type="checkbox"/> NO <input type="checkbox"/>	Is fluoride taken in any form? _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Does child brush teeth daily? _____	<input type="checkbox"/> <input type="checkbox"/>	Any injuries to mouth, teeth, head? _____	<input type="checkbox"/> <input type="checkbox"/>
Does child use floss every day? _____	<input type="checkbox"/> <input type="checkbox"/>	Any unhappy dental experiences? _____	<input type="checkbox"/> <input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc? _____			<input type="checkbox"/> <input type="checkbox"/>

(OVER)