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Child Registration and Health History

Date _____

Name _____ Master Miss

Address _____ City _____ State _____ Zip _____

Date of Birth ___/___/___ Sex: M F Home Phone (_____) _____

SSN _____ - _____ - _____ Name of School _____

Mother's name _____ Father's name _____

Address _____ Address _____

Date of Birth ___/___/___ SSN _____ Date of Birth ___/___/___ SSN _____

Work Phone (_____) _____ Work Phone (_____) _____

Emergency Contact _____ Phone (_____) _____

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

Dental Insurance Information

Name of Insured Parent _____ Date of Birth ___/___/___

ID# or SSN _____ BC/BS# _____ FEP R# _____

Employer Name, Address _____

Dental Insurance Co. _____ Address _____

Insurance Co. Phone (_____) _____ Policy # and/or Group # _____

Secondary Dental Coverage? No Yes: Please provide information on your coverage. We will be happy to file your secondary claim for you. You are responsible for all co-payments before your secondary insurance is filed. Your secondary insurance will be instructed to reimburse you directly.

Secondary Ins Co. Name, address and phone _____

I understand that I am responsible for the cost of this care regardless of insurance coverage and deductibles. I authorize release of information as it relates to my child's dental treatment and my insurance coverage.

Signature _____ Date _____

Please complete the other side of this form with your Dental and Medical History.

Dental History

Reason for today's visit? _____

At the present time, does your child have any dental complaints or concerns? _____

Child's last dental visit? _____ Previous dentist's name _____

Previous dentist's address _____ Phone (_____) _____

Medical History

Is your child under the care of a physician for any medical treatment? _____

Physician's name _____ Physician's address _____ Phone (_____) _____

Has there been any change in your child's general health in the last year? No Yes, please explain _____

Date of last physical examination _____ Please list any medications, including non-prescription, which your child is currently taking: _____

Has your child had any serious illnesses, operations or been hospitalized in the last 3 years? No Yes, please explain _____

Conditions (please mark all that apply):

- | | | | |
|---|---|--|-------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Rheumatic fever | Have you ever taken Fen-Phen? |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV+, AIDS | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> No |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tattoos | |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid condition | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tumors or growths | |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ulcer/stomach problems | |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Sexually transmitted diseases | |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Organ transplants | <input type="checkbox"/> Other, please explain: _____ | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pain in or near ears | <i>If female, please answer the following:</i> | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Taking birth control pills | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric conditions | <input type="checkbox"/> Pregnant: if so, how many months? _____ | |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Nursing | |

Allergies (please mark all that apply):

- | | | | |
|----------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | |
| <input type="checkbox"/> Jewelry | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Local anesthetics | |

Is there any other information the dentist should know? _____

I attest to the accuracy of the information on this form and hereby authorize Dr. Benavent or designated staff to perform necessary dental treatment mutually agreed upon by me as parent or legal guardian as may be required for my child's dental health.

Signature _____

Relationship _____ Date _____