

# CHILD'S REGISTRATION AND HISTORY

			Date
Child's name	Nickname	Age	Birth date
Residence address	City	State	Zip
School	Address	Grade	
Father's name	Mother's name		
Father employed by	How long	Home phone	Bus. phone
Mother employed by	How long	Home phone	Bus. phone
Person financially responsible (if other than parent)		Relationship to child	
Address	City	State	Zip Phone
Father's Social Security number			
Mother's Social Security number			
Father's birth date		Mother's birth date	

When dental insurance coverage name of carrier \_\_\_\_\_

Secondary insurance coverage, if any \_\_\_\_\_

Whom may we thank you for referring you \_\_\_\_\_

What is child's favorite: sport                      toy                      hobby                      person                      fictional character

## DENTAL HISTORY

	Yes	No		Yes	No
Date of last visit to a dentist _____			Does your child brush teeth daily _____	<input type="checkbox"/>	<input type="checkbox"/>
For what service _____			Do you assist child with tooth brushing _____	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Yes</b>	<b>No</b>	How often _____		
Has child complained about dental problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used _____	<input type="checkbox"/>	<input type="checkbox"/>
			How often _____		
Any unhappy dental experiences _____	<input type="checkbox"/>	<input type="checkbox"/>	Are disclosing tablets used _____	<input type="checkbox"/>	<input type="checkbox"/>
			Is fluoride taken in any form _____	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth - teeth - head _____	<input type="checkbox"/>	<input type="checkbox"/>			
			Do you desire complete dental service for the child _____	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	<input type="checkbox"/>	<input type="checkbox"/>			
			Child's attitude to dentistry _____		
Any unusual speech habits _____	<input type="checkbox"/>	<input type="checkbox"/>			
			Summary (for doctor's use) _____		
Any lost teeth _____	<input type="checkbox"/>	<input type="checkbox"/>			
Have missing teeth been replaced _____	<input type="checkbox"/>	<input type="checkbox"/>			
Orthodontic appliances worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>			

# HEALTH HISTORY

Child's physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

	Yes	No		Yes	No
Is child under care of physician now _____	<input type="checkbox"/>	<input type="checkbox"/>	Does child have good physical coordination _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Is child receiving any medication or drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Is there any excessive bleeding when cut _____	<input type="checkbox"/>	<input type="checkbox"/>	Summary (for doctor's use) _____		
_____			_____		
Has child ever been hospitalized _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Has child ever had surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Is there any allergy to penicillin or other drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Are there other allergies: food - pollen - animals - dust - other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		

**Has child any history of or difficulty with any of the following:**

- |   |  |                                       |  |   |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing      | <input type="checkbox"/> Mastoid         | <input type="checkbox"/> Thyroid          |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Heart        | <input type="checkbox"/> Measles         | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Mononucleosis   | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver        | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic Fever |   |

**Summary:** (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

May we request release of your child's medical records \_\_\_\_\_ **Yes No**

This information was discussed with and given by \_\_\_\_\_

Relation to child \_\_\_\_\_