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 | Driver license no. | State

Mother's Social Security number | Driver license no. | State

Father's birth date | Mother's birth date

Credit card name | No. | Expiration date

When dental insurance coverage name of carrier

Secondary insurance coverage, if any

Whom may we thank for referring you

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

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____

	Yes	No
Has child complained about dental problems _____	☐	☐
_____		
Any unhappy dental experiences _____	☐	☐
_____		
Any injuries to mouth - teeth - head _____	☐	☐
_____		
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	☐	☐
_____		
Any unusual speech habits _____	☐	☐
_____		
Any lost teeth _____	☐	☐
_____		
Have missing teeth been replaced _____	☐	☐
_____		
Orthodontic appliances worn now or ever been _____	☐	☐

	Yes	No
Does your child brush teeth daily _____	☐	☐
Do you assist child with tooth brushing _____	☐	☐
How often _____		
Is dental floss used _____	☐	☐
How often _____		
Are disclosing tablets used _____	☐	☐
Is fluoride taken in any form _____	☐	☐
_____		
Do you desire complete dental service for the child _____	☐	☐
_____		
_____		
Child's attitude to dentistry _____		
_____		
_____		
Summary (for doctor's use) _____		
_____		
_____		
_____		

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No
Is child under care of physician now	☐	☐
Is child receiving any medication or drugs	☐	☐
Is there any excessive bleeding when cut	☐	☐
Has child ever been hospitalized	☐	☐
Has child ever had surgery	☐	☐
Is there any allergy to penicillin or other drugs	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	Yes	No
Does child have good physical coordination	☐	☐
Are there any emotional problems	☐	☐

Summary (for doctor's use) _____

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

_____ Anemia	_____ Chronic sinus	_____ Hearing	_____ Mastoid	_____ Thyroid
_____ Asthma	_____ Convulsions	_____ Heart	_____ Measles	_____ Tuberculosis
_____ Bladder	_____ Diabetes	_____ Kidney	_____ Mononucleosis	_____ Veneral disease
_____ Cerebral Palsy	_____ Epilepsy	_____ Liver	_____ Mumps	_____ Other
_____ Chicken pox	_____ Fainting	_____ Malignancies	_____ 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.

	Yes	No
May we request release of your child's medical records for our reference	☐	☐

This information was discussed with and given by _____

Relation to child _____