

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 | Home phone | Bus. phone | |
| Mother employed by | Home phone | Bus. phone | |
| Person financially responsible (if other than parent) | Relationship to child | | |
| Address | City | State | Zip Phone |
| Father's Social Security number | State | | |
| Mother's Social Security number | State | | |
| Father's birth date | Mother's birth 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

| | 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"/> |
| Has child complained about dental problems _____ | <input type="checkbox"/> | <input type="checkbox"/> | How often _____ | | |
| Any unhappy dental experiences _____ | <input type="checkbox"/> | <input type="checkbox"/> | Is dental floss used _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Any injuries to mouth - teeth - head _____ | <input type="checkbox"/> | <input type="checkbox"/> | How often _____ | | |
| Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ | <input type="checkbox"/> | <input type="checkbox"/> | Are disclosing tablets used _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Any unusual speech habits _____ | <input type="checkbox"/> | <input type="checkbox"/> | Is fluoride taken in any form _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Any lost teeth _____ | <input type="checkbox"/> | <input type="checkbox"/> | Do you desire complete dental service for the child _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have missing teeth been replaced _____ | <input type="checkbox"/> | <input type="checkbox"/> | Child's attitude to dentistry _____ | | |
| Orthodontic appliances worn now or ever been _____ | <input type="checkbox"/> | <input type="checkbox"/> | Summary (for doctor's use) _____ | | |

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

Is child under care of physician now _____ **Yes No**

Does child have good physical coordination _____ **Yes No**

Is child receiving any medication or drugs _____

Are there any emotional problems _____

Is there any excessive bleeding when cut _____

Summary (for doctor's use) _____

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 _____

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 | _____ Venereal disease |
| _____ Cerebral Palsy | _____ Epilepsy | _____ Liver | _____ Mumps | _____ Other |
| _____ Chicken pox | _____ Fainting | _____ Malignancies | _____ Rheumatic fever | |

Summary: (for doctor's use)

[Empty box for doctor's summary]

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 for our reference _____ **Yes No**

This information was discussed with and given by _____
Relation to child _____