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 you 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 - thumb sucking, 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	___ Venereal 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 _____	☐	☐

This information was discussed with and given by _____

Relation to child _____