CHILD'S REGISTRATION AND HISTORY

DATE ____________________

PATIENT'S NAME ____________________

NICKNAME ____________________ AGE ____________________

ADDRESS ____________________

TELEPHONE # ____________________ DATE OF BIRTH ____________________

SCHOOL ____________________ GRADE ____________________

PARENT OR GUARDIAN'S NAME ____________________ TELEPHONE # ____________________

PLACE OF EMPLOYMENT ____________________ BUSINESS TELE. # ____________________

I WAS REFERRED BY ____________________

ADDRESS ____________________

COMPLETE IF YOU ARE COVERED UNDER DENTAL INSURANCE:

TYPE OF INSURANCE ____________________ MEMBERSHIP # ____________________

INSURANCE CARRIER ____________________ NAME OF EMPLOYEE ____________________

EMPLOYEE'S SOCIAL SECURITY # ____________________ RELATIONSHIP TO PATIENT ____________________

____
SIGNATURE OF PARENT OR GUARDIAN

DENTAL HISTORY

Date of last visit to a dentist ____________________

	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 ____________________	☐	☐
Orthodontic appliances worn now or ever been ____________________	☐	☐

	YES	NO
Do you assist child with tooth brushing ____________________	☐	☐
Is fluoride taken in any form ____________________	☐	☐

Child's attitude to dentistry ____________________

	YES	NO
Do you desire complete dental service for the child ____	☐	☐

Additional Comments: ____________________

(over)

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 ________	☐	☐
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	____Rheumatic Fever
____Asthma	____Convulsions	____Heart	____Measles	____Thyroid
____Bladder	____Diabetes	____Kidney	____Mononucleosis	____Tuberculosis
____Cerebal Palsey	____Epilepsy	____Liver	____Mumps	____Other
____Chicken Pox	____Fainting	____Malignancies		

SUMMARY: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be 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________________