Child's Registration and History

Child's Name (first & last) | Nickname | Date of Birth | Age

Address | City | State | Zip

School | Address | Grade

Home Phone Number

Responsible Party First & Last Name

Billing Address (if different from above)

Home Phone Number | Cell Number | Work Number

Dental Insurance Information

Dental Insurance Carrier | Claim's Address | Phone Number

Subscriber Name | Subscriber Social Security # | Member ID #

Employer

Dental History

Date of last dental visit_____
For what_____

Previous Dentist's Name_____
Phone Number_____

Any unhappy dental experiences? Yes No

Has child complained about any dental problems?

Any injuries to mouth, teeth or head? Yes No

Any mouth habits: thumbsucking, nail biting, mouthbreathing, etc?_____

Any lost teeth? Yes No

Does your child brush daily? Yes No
Do you assist your child with brushing? Yes No
How Often?_____
Is dental floss used? Yes No
How Often?_____
Are displacing tablets used? Yes No
Is fluoride taken in any form? Yes No

Child's attitude towards dentistry_____

(over)

Medical History

Child's Physician_____Phone Number_____
Address_____

Date of last complete physical examination_____Results_____

Is your child in good health? Yes No
Is your child receiving any medications, Vitamins, or OTC drugs? Yes No
Has your child ever had surgery?_____

Is your child currently seeing a physician? Yes No
Child's weight_____ height_____
Has your child ever been hospitalized?_____

What are your child's eating habits?_____

Any psychological or emotional problems you would like to bring to our attention?_____

Is your child allergic to any of the following?

- o Penicillin
- o Latex
- o Aspirin
- o Codeine
- o Acrylic
- o Metal
- o Local anesthetics
- o Other

Does your child have any of the following conditions?

- o Rheumatic fever or rheumatic heart disease.
- o Congenital heart disease or heart murmur.
- o Asthma or hay fever.
- o Arthritis or rheumatism.
- o Diabetes or blood sugar problems.
- o Any prolonged bleeding or bruises easily.
- o Kidney or bladder problems.
- o Anemia or blood disorders.
- o Tuberculosis or pneumonia.
- o Liver problems or jaundice or hepatitis.
- o Glandular or hormonal problems.
- o Accidents or severe infections.
- o Convulsion, seizures, fainting or epilepsy.
- o High / low blood pressure.
- o Speech, learning, or hearing disorders.
- o Childhood illnesses.
- o Immunizations.
- o Other, if so explain.

I hereby certify the foregoing information is correct and true. This patient is a minor, therefore it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or necessary dental treatment is performed. Authorization is hereby granted as such. Furthermore, I will be responsible for any professional fees incurred for dental services to my child.

_____

Signature of parent or guardian Date