# Child's Registration & Health History Questionnaire

**You, as a parent, want to help your child to good oral health. Modern science is making many important contributions to better oral health, but the individual must still take the major responsibility for the care of his/her own mouth. You can teach your child to do so. With proper personal and professional care, your child may keep his/her teeth all his life.**

DATE ______________________

CHILD'S NAME ______________________ DATE OF BIRTH ______________________

SCHOOL ______________________ GRADE ______________________

RESIDENCE ______________________

CITY ______________________ STATE __________ ZIP ______________________

FATHER'S NAME ______________________ CELL PHONE ______________________

ADDRESS ______________________ HOW LONG? ______________________

EMPLOYED BY ______________________ HOME PHONE / BUS. PHONE ______________________

MOTHER'S NAME ______________________ CELL PHONE ______________________

ADDRESS ______________________ HOW LONG? ______________________

EMPLOYED BY ______________________ HOME PHONE / BUS. PHONE ______________________

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? __________ NAME OF INSURANCE COMPANY ______________________

______________________ POLICY NUMBER ______________________

______________________ UNION (LOCAL #) ______________________ UNION HEAD ______________________

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT ______________________

______________________

ANY BROTHERS OR SISTERS? ______________________ LIST AGES ______________________

IS THIS YOUR CHILD'S FIRST DENTAL EXPERIENCE? ______________________

WHAT IS THE CHILD'S ATTITUDE TOWARDS THIS VISIT? ______________________

COMMENTS: ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________

THANK YOU

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LAST NAME ______________ FIRST NAME ______________ DATE OF EXAM ______________

## MEDICAL HEALTH HISTORY

General Health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is child's physician?

Physician's Address?

When did child have last complete physical examination?

Is child being treated for anything now?

Did child ever have:

| | | | |
|---|---|---|---|
| ☐ Kidney Disease | ☐ AIDS or HIV + | ☐ Hearing Problem | ☐ High Cholesterol |
| ☐ Diabetes | ☐ Anemia | ☐ Bone Disorders | ☐ Other: |
| ☐ Rheumatic Fever | ☐ Asthma | ☐ Endocrine | ______ |
| ☐ Hepatitis | ☐ Heart Trouble | ☐ Arthritis | ______ |
| ☐ Liver Disease | ☐ Epilepsy / Convulsions | ☐ Broken Bones | ______ |
| ☐ Tuberculosis | ☐ Speech Impediment | ☐ High Fever | |

| | Yes | No |
|---|---|---|
| Is child allergic to: ☐ Penicillin ☐ Codeine ☐ Novocaine ☐ Latex ☐ Other | | |
| Is child taking any medications now? If so, what? | | |
| Does child have any allergies? | | |
| Is child subject to prolonged bleeding? | | |
| Does child have any emotional problems? | | |

I VERIFY THE ABOVE AND GIVE MY CONSENT FOR TREATMENT

______________________________

Parent or Guardian Signature

## DENTAL HEALTH HISTORY – CHILD

1. How long since child's last dental examination?
2. What concerns you most about your child's dental health?
3. Does your child ever have dental pain? If so, when?
4. Did child ever have a negative dental experience?

   Discuss
5. Has the patient had any injuries to the face? ______________

   ______________ (please check)

   ☐ mouth ☐ teeth ☐ face
6. Has the patient ever sucked a thumb or fingers?

   Until what age? ________
7. Does the patient have any speech problems?
8. Is the patient a mouth-breather?

   While awake? ________ While asleep? ________
9. Has the child had teeth removed?
10. Has child had orhtodontic treatment?
11. How often does your child brush?

    Floss?
12. Has child received any flouride treatment?

    ☐ pill / vitamins ☐ topical ☐ water
13. Are you happy with the appearance of child's teeth?

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NAME ____________________

HOME PHONE ____________ BUS. PHONE ____________

CELL PHONE ____________

INSURANCE CO. ____________

PRE. AUTH. DATE SENT ____________

DATE REC. ____________

UNION ____________

MOBILITY 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16

A B C D E | F G H I J

*RIGHT* — *LINGUAL* — *LEFT*

T S R Q P | O N M L K

32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17

MOBILITY 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

## ORAL TISSUE EXAMINATION

LIPS ____________

CHEEKS ____________

TONGUE ____________

FLOOR OF MOUTH ____________

PALATE ____________

TONSILLAR AREA ____________

TMJ ____________

ORAL HYGIENE ____________

INFLAMMATION OF GINGIVAL TISSUE

☐ SLIGHT ☐ MODERATE ☐ SEVERE

CALCULUS

☐ SLIGHT ☐ MODERATE ☐ SEVERE

RECESSION

☐ SLIGHT ☐ MODERATE ☐ SEVERE

| Tooth # or Letter | SURFACE | DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO. | DATE SERVICE PERFORMED MO DAY YEAR | | | |
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### FINANCIAL AGREEMENT

DATE ____________

NAME ____________

DR. ____________

# VISITS ____________

PREPARED BY ____________

The named procedures, risks, and alternatives have been fully explained and I hereby consent to the proposed treatment.

I also understand that I'm financially responsible for any charges not paid by the Insurance Company.

SIGNATURE

____________

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| DATE OF SERVICE | Tooth # | TREATMENT RENDERED | FEE | Dr. Initials |
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