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 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 - thumbsucking, 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) ____________

Item 21022

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	__ Veneral 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 for our reference ______________	☐	☐

This information was discussed with and given by ______________________

Relation to child ______________________