

# 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:	toy	hobby	person	fictional character

## DENTAL HISTORY

	Yes	No	Yes	No
Date of last visit to a dentist _____			Does your child brush teeth daily _____	<input type="checkbox"/> <input type="checkbox"/>
For what service _____			Do you assist child with tooth brushing _____	<input type="checkbox"/> <input type="checkbox"/>
Has child complained about dental problems _____	<input type="checkbox"/>	<input type="checkbox"/>	How often _____	
Any unhappy dental experiences _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used _____	<input type="checkbox"/> <input type="checkbox"/>
Any injuries to mouth - teeth - head _____	<input type="checkbox"/>	<input type="checkbox"/>	How often _____	
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	<input type="checkbox"/>	<input type="checkbox"/>	Are disclosing tablets used _____	<input type="checkbox"/> <input type="checkbox"/>
Any unusual speech habits _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form _____	<input type="checkbox"/> <input type="checkbox"/>
Any lost teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you desire complete dental service for the child _____	<input type="checkbox"/> <input type="checkbox"/>
Have missing teeth been replaced _____	<input type="checkbox"/>	<input type="checkbox"/>	Child's attitude to dentistry _____	
Orthodontic appliances worn now or ever been _____	<input type="checkbox"/>	<input type="checkbox"/>	Summary (for doctor's use) _____	

**HEALTH HISTORY**

Child's physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

	Yes	No		Yes	No
Is child under care of physician now _____	<input type="checkbox"/>	<input type="checkbox"/>	Does child have good physical coordination _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Is child receiving any medication or drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Is there any excessive bleeding when cut _____	<input type="checkbox"/>	<input type="checkbox"/>	Summary (for doctor's use) _____		
_____			_____		
Has child ever been hospitalized _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Has child ever had surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Is there any allergy to penicillin or other drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Are there other allergies: food - pollen - animals - dust - other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		

**Has child any history of or difficulty with any of the following:**

- |   |  |                                       |  |   |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Chronic sinus | <input type="checkbox"/> Hearing      | <input type="checkbox"/> Mastoid         | <input type="checkbox"/> Thyroid          |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Heart        | <input type="checkbox"/> Measles         | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Mononucleosis   | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver        | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Malignancies | <input type="checkbox"/> 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May we request release of your child's medical records for our reference \_\_\_\_\_ **Yes No**

This information was discussed with and given by \_\_\_\_\_

Relation to child \_\_\_\_\_