# CHILD'S REGISTRATION & HISTORY FORM

**Please list any medications your child is taking**_____

_____

**Is there any disease, condition, or problem that you think that this office should know about that is not covered in the medical section?** _____

**How did you hear about our office?**_____

**Mother's Last Name**_____ **First Name** _____**M.I.**_____

**Address** _____**City** _____ **State** ____ **Zip** _____

**Home Phone (**____**)**_____**Bus.Phone (**____**)**_____ **Cell Phone(**____**)**_____

**Date of Birth**___/___/___**Social Security#**____-___-_____**E-Mail Address**_____

**Employer** _____ **Employer's Address** _____

**Father's Last Name**_____ **First Name** _____**M.I.**_____

**Address** _____**City** _____ **State** ____ **Zip** _____

**Home Phone (**____**)**_____**Bus.Phone (**____**)**_____ **Cell Phone(**____**)**_____

**Date of Birth**___/___/___**Social Security#**____-___-_____**E-Mail Address**_____

**Employer** _____ **Employer's Address** _____

## DENTAL HISTORY

**Date of last dental visit**_____ **Treatment Received**_____

**How would you describe your child's previous dental experiences?** _____

_____

**Is your water fluoridated? [ ]Yes [ ]No [ ]Don't know**

**Have sealants ever been placed on the child's teeth? [ ]Yes [ ]No**

**Does your child have any habits that may affect their teeth (such as thumb sucking)?**

***I certify that the above information is complete and accurate.***

***Parent/Guardian's Signature***_____***Date*** _____/_____/_____