CHILD'S REGISTRATION & HISTORY
WELCOME TO OUR PRACTICE

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 | Cell phone

Mother employed by | How long | Home phone | Bus. phone | Cell phone

Person financially responsible (if other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | State

Mother's Social Security number | State

Father's birth date | Mother's birth 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

What is the reason for your visit today?_____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

	YES	NO
Has child complained about dental problems _____	❑	❑
How do you think your child will do _____	❑	❑
Any injuries to mouth - teeth - head _____	❑	❑
Any mouth habits - thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, grinding teeth, etc.	❑	❑
Does the child eat sweets _____	❑	❑
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/flossing _____	❑	❑
How often _____		
Is fluoride taken in any form _____	❑	❑
Do you desire complete dental service for the child _____	❑	❑
Any special concerns about your child's dental health _____	❑	❑

Summary (for doctor's use)_____

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	❑	❑
Is your child allergic or sensitive to any metals or latex _____	❑	❑

	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
- ❑ Asthma
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Chicken pox
- ❑ Chronic sinus
- ❑ Congenital Birth Defects
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Hearing
- ❑ Hepatitis
- ❑ Heart Problems
- ❑ Heart Murmur
- ❑ Kidney
- ❑ Liver
- ❑ Malignancies
- ❑ Mononucleosis
- ❑ Prolonged Bleeding
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Other

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 _____