## 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

| | Yes | No |
|---|---|---|
| Date of last visit to a dentist | | |
| For what service | | |
| 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 | ☐ | ☐ |
| 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) | | |

## HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Is child under care of physician now_____ | ☐ | ☐ | Does child have good physical coordination _____ | ☐ | ☐ |
| Is child receiving any medication or drugs _____ | ☐ | ☐ | Are there any emotional problems _____ | ☐ | ☐ |
| Is there any excessive bleeding when cut _____ | ☐ | ☐ | Summary (for doctor's use) _____ | | |
| 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 | ☐ | ☐ | | | |

**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 _____