PEDIATRIC DENTISTRY SHELLIE BRANSON D.M.D.
2015 HERR LANE STE D. LOU KY 40222 502.426.0088 FAX 426.7828

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

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 flouride 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 Number _____

Date of last physical examination _____ Results _____

	Yes	No
Is child under care of physician now	☐	☐
Is child receiving any medications or drugs	☐	☐
Is there any excessive bleeding when cut	☐	☐
Has child ever been hospitalized	☐	☐
IHas 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 _____