

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

<p>Date of last visit to a dentist _____</p> <p>For what service _____</p> <p>Has child complained about dental problems _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any unhappy dental experiences _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any injuries to mouth - teeth - head _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any unusual speech habits _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any lost teeth _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have missing teeth been replaced _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Orthodontic appliances worn now or ever been _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<table border="0" style="width:100%;"> <tr> <td style="width:80%;"></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>Does your child brush teeth daily _____</td> <td style="text-align: right;"><input type="checkbox"/></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Do you assist child with tooth brushing _____</td> <td style="text-align: right;"><input type="checkbox"/></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>How often _____</td> <td></td> <td></td> </tr> <tr> <td>Is dental floss used _____</td> <td style="text-align: right;"><input type="checkbox"/></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>How often _____</td> <td></td> <td></td> </tr> <tr> <td>Are disclosing tablets used _____</td> <td style="text-align: right;"><input type="checkbox"/></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Is flouride taken in any form _____</td> <td style="text-align: right;"><input type="checkbox"/></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td>Do you desire complete dental service for the child _____</td> <td style="text-align: right;"><input type="checkbox"/></td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Child's attitude to dentistry _____</td> </tr> <tr> <td colspan="3">Summary (for doctor's use) _____</td> </tr> </table>		Yes	No	Does your child brush teeth daily _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist child with tooth brushing _____	<input type="checkbox"/>	<input type="checkbox"/>	How often _____			Is dental floss used _____	<input type="checkbox"/>	<input type="checkbox"/>	How often _____			Are disclosing tablets used _____	<input type="checkbox"/>	<input type="checkbox"/>	Is flouride taken in any form _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you desire complete dental service for the child _____	<input type="checkbox"/>	<input type="checkbox"/>	Child's attitude to dentistry _____			Summary (for doctor's use) _____		
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HEALTH HISTORY

Child's physician _____ Address _____ Phone Number _____

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 medications 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.

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 _____