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 you 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 - thumb sucking, 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 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	___ Venereal 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 ______	☐	☐

This information was discussed with and given by ______

Relation to child ______