CHILD'S REGISTRATION AND HISTORY

Date

Child's name Nickname Age Birth Date

Residence address City State Zip

School Address

Father's name Mother's name

Father employed by How long Home phone Cell phone

Mother employed by How long Home phone Cell phone

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

Address City State Zip Phone

Father's Social Security number Driver's license number State

Mother's Social Security number Driver's license number State

Credit Card name CC number Expiration date

When dental insurance coverage began Name of carrier

Secondary insurance coverage, if any

Whom may we thank for referring you

What is your child's favorite: Sport Toy Hobby Person Fictional Character

DENTAL HISTORY

Date of last visit to dentist ______________ For what service ______________

	Yes	No			Yes	No
Does your child brush teeth daily	☐	☐	Do you assist (how often)	______________	☐	☐
Is dental floss used	☐	☐	How often	______________		
Are plaque disclosing tablet used	☐	☐	How often	______________		

	Yes	No	If yes, please explain
Is fluoride taken in any form	☐	☐	
Has child complained of dental problems	☐	☐	
Any injuries to mouth/teeth/head	☐	☐	
Any unhappy dental experiences	☐	☐	
Any unusual speech habits	☐	☐	
Any lost teeth	☐	☐	
Have missing teeth been replaced	☐	☐	
Orthodontics use now or in the past	☐	☐	
Do you desire complete dental services	☐	☐	

Any mouth habits: Thumb sucking ☐, Nail biting ☐, Mouth breathing ☐, Nursing bottle habits ☐, Pacifier ☐, Other ☐ Please explain ______

Child's attitude towards dentistry ______

Summary (for Doctor's use) ______

HEALTH HISTORY

Child's physician ______ Address ______ Phone ______

Date of last physical examination ______ Results ______

	Yes	No	If yes, please explain
Is child currently under a physicians care	☐	☐	
Is child receiving any medication or drugs	☐	☐	
Is there any excessive bleeding when cut	☐	☐	
Has child ever been hospitalized	☐	☐	
Have child ever had surgery	☐	☐	
Is there any allergy to penicillin or other drugs	☐	☐	
Other allergies (food, pollen, animals, dust, etc)	☐	☐	
Does child have good physical coordination	☐	☐	
Are there any emotional problems	☐	☐	

Summary (for Doctor's use) ______________________________

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Has child had any history of or difficulty with any of the following

☐ Anemia	☐ Chronic Sinusitis	☐ Hearing	☐ Mastoid	☐ Thyroid
☐ Asthma	☐ Convulsions	☐ Heart	☐ Measles	☐ Tuberculosis
☐ Bladder	☐ Diabetes	☐ Kidney	☐ Mononucleosis	☐ Cerebral Palsy
☐ Epilepsy	☐ Venereal Disease	☐ Liver	☐ Mumps	☐ Rubella
☐ Chicken Pox	☐ Fainting	☐ Malignancies	☐ Rheumatic Fever	

Summary (for Doctor's use) ______________________________

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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

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May we request releases of your child's medical records Yes ☐ No ☐

This information was discussed and given by ______________________________

Relation to child ______________________________