Child's Registration History

Child's Social Security No._____ Date _____

Child's Name_____Name Child Goes By _____Age _____ DOB _____

Address _____ City _____ State _____ Zip _____

School _____ Grade _____

Father's Name _____ Mother's Name _____

Home Phone _____ Cell_____Email _____

Father Employed By _____Business Phone _____

Mother Employed By _____Business Phone _____

Person Financially Responsible (If other than Parent or in case of Divorce, which Parent)

_____Phone _____

Address _____ City _____ State _____ Zip _____

Is there any Dental Insurance Coverage on child? ❑ Yes ❑ No

Insurance Co._____ Phone _____ Insured Person _____

Social Security No. of Insured_____DOB of Insured_____ Group No. _____

Favorite Toy _____ Favorite Hobby _____

Favorite Person _____ Favorite Fictional Character_____

Whom may we thank for referring you to our office _____

Dental History

Date of Last Dental Visit _____

What was done at that time_____

Has the child complained about dental problems?	No ❑	Yes ❑
Any unhappy dental experiences?	No ❑	Yes ❑
Any injuries to mouth or teeth?	No ❑	Yes ❑
Any mouth habits - thumbsucking, nailbiting, pacifier, other_____(if yes, circle)	No ❑	Yes ❑
Any unusual speech habits?	No ❑	Yes ❑
Has the child ever worn orthodontic appliances?	No ❑	Yes ❑
Does the child brush teeth daily?	No ❑	Yes ❑
Does the child use dental floss? How often? _____	No ❑	Yes ❑
Is flouride used in any form?	No ❑	Yes ❑

What is the child's attitude toward dentistry? _____

_____

Medical History

Child's Physician _____Phone _____

Address _____

Is there any allergy to penicillin or any other drugs? _____

_____

Has child ever had a blood test for Hepatitis or AIDS? No ❑ Yes ❑

Is there anything we should know about child's heath? _____

_____

Circle any of the following which child has had or now has:

(Please specify at bottom)

- Rheumatic Fever
- Heart Murmur
- Mitral Valve Prolapse
- Other Heart-Related Problems (specify below)
- Has child a joint replacement or prothesis (specify below)
- High Blood Pressure
- Anemia
- Any current or re-current illness (specify below)
- Unintentional weight loss
- Lymphadenopathy or any oral soft tissue lesions
- Has child had a transplant (specify below)
- Headaches or Earaches
- Thyroid
- Kidney or Dialysis
- Glaucoma
- Venereal Disease
- Herpes
- Tuberculosis
- Diabetes
- Asthma
- Hepatitis-Type
- AIDS

_____

_____

_____

_____

Parent or Guardian Signature

Have there been any changes in the child's medical history since his / her last visit?

Date	Changes if any	Initials	Date	Changes if any	Initials