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CHILD'S REGISTRATION AND HISTORY

Child's Name	Nickname	Age	Birthday

Residence Address	City	State	Zip Code

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 Code

Father's Social Security Number	Father's Birthday	Driver's License No.	State

Mother's Social Security Number	Mother's Birthday	Driver's License No.	State

Credit Card No.	Name on Credit Card	Expiration

Dental Insurance Company Name	Secondary Dental Insurance Company Name (if applicable)

Child's Favorite Sport:	Child's Favorite Toy:	Child's Favorite Hobby:	Child's Favorite Person:	Child's Favorite Fictional Character:

CHILD'S DENTAL HISTORY

- Date of last visit to a dentist? _____
- For what service? _____
- Has child complained about dental problems: ☐ Yes ☐ No
  If yes, please explain: _____
- Any unhappy dental experiences? ☐ Yes ☐ No
  If yes, please explain: _____
- Any injuries to mouth - teeth - head? ☐ Yes ☐ No
  If yes, when? _____
- Any mouth habits:
  ☐ Thumb sucking ☐ Nail biting ☐ Mouth breathing ☐ Nursing bottle habits ☐ Pacifier
- Any unusual speech habits? ☐ Yes ☐ No
  If yes, please explain: _____
- Any lost teeth? ☐ Yes ☐ No
- Have missing teeth been replaced? ☐ Yes ☐ No
  If yes, when? _____

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- Orthodontic appliances worn now or ever been? ☐ Yes ☐ No

  If yes, when? _____
- Does your child brush teeth daily? ☐ Yes ☐ No
- How often: ☐ Daily ☐ Twice a day
- Do you assist child with tooth brushing? ☐ Yes ☐ No
- Is dental floss used? ☐ Yes ☐ No
- Are disclosing tablets used? ☐ Yes ☐ No
- Is fluoride taken in any form? ☐ Yes ☐ No
- Do you desire complete dental service for the child? ☐ Yes ☐ No
- Child's attitude to dentistry? _____
- Summary (for doctor's use) _____

_____

CHILD'S MEDICAL HISTORY

Child's Physician	Address	Phone

Date of Last Examination	Results

- Is the chind under care of a physician now? ☐ Yes ☐ No

  If yes, how? _____
- Is the child receiving any medications or drugs? ☐ Yes ☐ No

  If yes, please explain: _____
- Is there any excessive bleeding when cut? ☐ Yes ☐ No
- Has child ever been hospitalized? ☐ Yes ☐ No

  If yes, when? _____
- Has child ever had surgery? ☐ Yes ☐ No

  If yes, when? _____
- Is there any allergy to penicillin or other drugs? ☐ Yes ☐ No

  If yes, please explain: _____
- Are there other allergies: food - pollen - animals - dust - other? ☐ Yes ☐ No

  If yes, please explain: _____
- Does child have good physcial coordination? ☐ Yes ☐ No
- Are there any emotional problems? ☐ Yes ☐ No

  If yes, please explain: _____

Please indicate which of the following you have had or have at present.

☐ 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	

- 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: _____

_____

_____

- May we request release of your child's medical records? ☐ Yes ☐ No
- This information was given by: _____
- Relationship to child: _____