CHILD'S REGISTRATION AND HISTORY

DATE ______

CHILD'S NAME ______ NICKNAME ______ AGE ______ DATE OF BIRTH ______

SCHOOL ______ GRADE ______ RESIDENCE ADDRESS ______

CITY ______ STATE ______ ZIP ______

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 ______

PARENT'S SOCIAL SECURITY NUMBER ______ DRIVER LICENSE NO. ______ STATE ______

CREDIT CARD NAME ______ NO. ______ EXPIRATION DATE ______

WHEN DENTAL INSURANCE COVERAGE NAME OF CARRIER ______

WHOM MAY WE THANK FOR REFERRING YOU ______

WHAT IS CHILD'S FAVORITE SPORT ______ FAVORITE TOY ______

FAVORITE HOBBY ______ FAVORITE PERSON ______ FAVORITE FICTION 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 - thumbsucking, 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 ______	☐	☐
Child's attitude to dentistry ______		
Do you desire complete dental service for the child ______	☐	☐

Summary (for doctor's use) ______

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HEALTH HISTORY

Child's Physician ____________ Address ____________ Phone ____________

Date of last physical examination ____________ Results ____________

	YES	NO
Is child under care of physician now ____________	☐	☐
Is child receiving any medication or drugs ____________	☐	☐
Is there any excessive bleeding when cut ____________	☐	☐
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	☐	☐

	YES	NO
Does child have good physical coordination ____________	☐	☐
Are there any emotional problems ____________	☐	☐

Summary (for doctor's use) ____________

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	___ Other
___ Cerebral Palsy	___ Epilepsy	___ Liver	___ Mumps	___ Venereal Disease
___ 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 for our reference ____________	☐	☐

This information was discussed with and given by ____________

Relation to Child ____________