Child's Registration and History

Please fill out the following information to the best of your knowledge.

Date:_____

Patient Information

Name:_____ DOB:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Contact Number: (home)_____(work)_____(cell)_____

Father's Name:_____ Contact #:_____ Employer:_____

Mother's Name:_____ Contact #:_____ Employer:_____

Insurance Information

Name of Insured:_____ DOB:_____ SSN: _____

Relationship to Patient:_____ Name of Employer:_____

Person Responsible for Account:_____

Medical Health

Physician:_____ Phone:_____ Date of Last Exam:_____

	Y	N
- Is child under any medical treatment now?	☐	☐
- Has child been hospitalized for any surgical operations or serious illness within the last 5 years? If yes, please explain: _____	☐	☐
- Is child currently taking any medication(s)?	☐	☐
- Please list current medications:_____ _____ _____		
- For what purpose:_____ _____		

	Y	N
- Is child allergic to any of the following?		
• Local Anesthetics.....	☐	☐
• Penicillin (other Antibiotics).....	☐	☐
• Sulfa Drugs.....	☐	☐
• Codeine.....	☐	☐
• Other (please list).....	☐	☐
- Is child subject to prolonged bleeding?..	☐	☐
- Does child have good physical coordination?.....	☐	☐
- Does child have behavioral issues?.....	☐	☐

Have you ever been treated for:

• Anemia.....	☐	☐	• Hearing.....	☐	☐
• Asthma.....	☐	☐	• Heart.....	☐	☐
• Cerebral Palsy.....	☐	☐	• Kidney.....	☐	☐
• Chicken Pox.....	☐	☐	• Liver.....	☐	☐
• Chronic Sinus.....	☐	☐	• Thyroid.....	☐	☐
• Convulsions.....	☐	☐	• Tuberculosis.....	☐	☐
• Diabetes.....	☐	☐	• Other.....	☐	☐
• Epilepsy.....	☐	☐			
• Fainting.....	☐	☐			

(over)

Dental Health

Previous Dentist and Location/Phone:_____Date of Last Exam:_____

	Y	N
- Has child complained about dental problems?	☐	☐
- Any unhappy dental experiences?	☐	☐
- Any injuries to mouth, teeth, or head?	☐	☐
- Any mouth habits? (thumb sucking, nail biting, mouth breathing, pacifier).....	☐	☐
- Any unusual speech habits?	☐	☐
- Any lost teeth?	☐	☐
- Have missing teeth been replaced?	☐	☐
- Has child ever experienced any of the following problems in their jaw?	☐	☐
- Orthodontic appliance past or present?	☐	☐
- Does child brush teeth daily?	☐	☐
- Do you assist child with tooth brushing?	☐	☐
o How often?_____		
- Is dental floss used?	☐	☐
o How often?_____		
- Is fluoride taken in any form?	☐	☐

- Child's attitude to dentistry_____
- What/Who is child's favorite:
  - o Sport_____
  - o Toy_____
  - o Hobby_____
  - o Person_____
  - o Fiction Character_____

Please add anything you feel is important:

_____

_____

_____

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Parent Signature