REGISTRATION AND HISTORY

DATE _____

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

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

SCHOOL _____ 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) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHEN DENTAL INSURANCE COVERAGE, NAME OF CARRIER _____

WHOM MAY WE THANK FOR REFERRING YOU _____

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 _____	☐	☐
Orthodontic appliances worn now or ever been _____	☐	☐
Does your child brush daily _____	☐	☐
Do you assist child with tooth brushing _____	☐	☐
How often _____		
Is dental floss used _____	☐	☐
Is fluoride taken in any forms _____		

Child's attitude to dentistry _____

Do you desire complete dental service for the child _____

HEALTH HISTORY

Child's physician _____

Address _____ Phone _____

Date of last 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 _____	☐	☐

IS THERE ANY ALLERGY TO LATEX OR NATURAL RUBBER PRODUCTS_____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

— Anemia	— Emotional Problems	— Measles
— Asthma	— Epilepsy	— Mononucleosis
— Bladder	— Fainting	— Mumps
— Cerebral Palsy	— Hearing	— Rheumatic Fever
— Chicken Pox	— Heart	— Thyroid
— Chronic Sinus	— Kidney	— Tuberculosis
— Convulsions	— Liver	— Venereal Disease
— Diabetes	— Malignancies	— Other

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 FOR OUR REFERENCE YES ☐ NO ☐

Parent or Guardian's Signature _____