

CHILD'S REGISTRATION AND HISTORY

CHILD'S PERSONAL INFORMATION

Today's Date: _____ Child's Full Name: _____

Child's Age: _____ Birthdate: _____ Social Security # _____ - _____ - _____ Nickname: _____

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

School: _____ Grade: _____ School Address: _____

Child's Favorites: Sport: _____ Toy: _____ Hobby: _____

Family Email Address: _____

PARENT/GUARDIAN INFORMATION

Father's Full Name: _____ Social Security # _____ - _____ - _____ Driver License # _____

Father's Birthdate: _____ Father's Employer: _____ How Long: _____

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

Father's Home Phone: _____ Cell Phone _____ Work Phone _____ Email: _____

Mother's Full Name: _____ Social Security # _____ - _____ - _____ Driver License # _____

Mother's Birthdate: _____ Mother's Employer: _____ How Long: _____

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

Mother's Home Phone: _____ Cell Phone _____ Work Phone _____ Email: _____

Person financially responsible for child (if other than parent): _____

Relationship to child: _____ Social Security # _____ - _____ - _____ Driver License # _____

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

Home Phone: _____ Cell Phone _____ Work Phone _____ Email: _____

INSURANCE INFORMATION

Do you have dental insurance: _____ yes _____ no - if yes, we will need a copy of your insurance card today.

Name of dental insurance company: _____ Insurance Group # _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative, not living with you: _____

Relationship to child: _____ Home Phone: _____ Cell Phone: _____

Referral Information

Whom may we thank for referring you to our dental office? _____

OVER - Please complete the reverse side of this form.

DENTAL HISTORY

Date of last dental visit: _____ What was done: _____

Any dental problems child has complained about or mentioned: _____

Any injuries to mouth, teeth or head: _____

Any mouth habits (bottle, pacifier, thumbsucking, biting nails, etc..) _____

Any unusual speech habits? _____ Have orthodontics ever been worn? _____

Any lost teeth? _____ Have missing teeth been replaced? _____

Does your child brush teeth daily? _____ How many times each day? _____ Do you assist? _____

Is dental floss used? _____ Do you assist? _____ Are disclosing tablets used? _____

Is your drinking water fluoridated? _____ Are any other fluoride taken (in any form)? _____

Child's attitude toward dentistry (any unhappy experiences?) _____

Do you desire complete dental service for your child? _____

HEALTH HISTORY

Child's Physician: _____ Address: _____ Phone: _____

Date of last exam: _____ Results: _____ Currently under physician care? _____

List any medication or drugs being taken by child: _____

Has child ever had surgery: _____ If yes, for what: _____

Has child been hospitalized: _____ If yes, for what: _____

Does child bleed excessively when cut? _____ Does Child have good coordination? _____

Are there any emotional issues or other items we should be aware of? _____

ALLERGIES

OTHER

Has child ever been allergic to, or reacted adversely to (circle yes or no):

Penicillin	yes	no	Explain: _____
Sulfa Drugs	yes	no	Explain: _____
Barbiturates	yes	no	Explain: _____
Aspirin	yes	no	Explain: _____
Codeine/Narcotics	yes	no	Explain: _____
Latex	yes	no	Explain: _____
Other Antibiotics	yes	no	Explain: _____
Food Allergies	yes	no	Explain: _____
Other	yes	no	Explain: _____

Does child have any history of or difficulty with any of the following (check if yes):

___ Anemia	___ Asthma	___ Bladder
___ Cerebral Palsy	___ Chicken Pox	___ Chronic Sinus
___ Convulsions	___ Epilepsy	___ Diabetes (Type: _____)
___ Fainting	___ Hearing	___ Heart
___ Kidney	___ Liver	___ Malignancies
___ Mastoid	___ Measles	___ Mononucleosis
___ Mumps	___ Thyroid	___ Rheumatic Fever
___ Tuberculosis	___ Venereal Disease	
___ Other (_____)		

May we request release of your child's medical records for our reference? _____

This information was completed by: _____ Relationship to child: _____

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever a change in health or in medication, I will inform the dentist at the next appointment. Your signature authorizes us to make credit inquiries in case installment payment options are needed.

Signature of Parent/Guardian: _____ Date: _____