Child's Registration & Health History

Child's Name _____ Nick Name _____ Date of Birth_____

Address_____ City _____ State _____ Zip Code_____

Home Phone #: _____ School _____ Grade _____

Father's Name _____ Father's Birth Date _____

Father Employed by: _____ Father's Home Phone #_____ Father's Work #_____

Father's Dental Insurance Carrier:_____ Group #_____

Father's Social Security # _____ Father's Driver's License #_____ State_____

Mother's Name _____Mother Birth Date_____

Mother Employed by: _____ Mother's Home Phone #_____ Mother's Work #_____

Mother's Dental Insurance Carrier:_____ Group #_____

Mother's Social Security # _____ Mother's Driver's License #_____ State_____

Person Financially Responsible (If other than parent) _____ Relationship to Child _____

What is Your Child's Favorite Sports: _____ Favorite Toy: _____

Favorite Hobby _____ Favorite Person _____

Favorite Fictional Character_____ Favorite Sports Team _____

Child's Medical History

Child's Physician _____ Address _____ Phone # _____

Date of last physical exam _____ Results_____

Please write answers, yes or no and explain if necessary:

Is your child under the care of a physician now: _____ Explain: _____

Does your child have good physical coordination _____ If no, Explain: _____

Does your child have any emotional problems? _____ Explain: _____

Is your child taking any medications or drugs? _____ Please list : _____

Does you child have any excessive bleeding when cut? _____ Explain: _____

Has your child ever been hospitalized? _____ Explain: _____

Has your child ever had surgery? _____ Explain: _____

Is your child allergic to penicillin? Or any other drugs? _____ Explain: _____

Are there any other allergies, (e.g. food, pollen, animals, dust)? _____ Explain: _____

Has your child had or have difficulty with any of the following?

____Anemia	____Sinus	____Hearing	____Thyroid Disease	____Asthma
____Convulsions	____Heart Disease	____Measles	____Tuberculosis	____Bladder
____Diabetes	____ Kidney Disease	____Mononucleosis	____Cerebral Palsy	____Epilepsy
____Liver Disease	____Mumps	____ Venereal Disease	____ Chicken Pox	____Fainting
____ Malignancies	____ Rheumatic Fever	____Other		

Please explain any of the previous checked off medical conditions: _____

_____

_____

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

Child's Dental History

Date of your child's last visit to a dentist? _____ For what reason? _____

Does your child brush their teeth daily? _____ How often? _____

Do you assist your child with tooth brushing?_____

Does your child use floss? _____ How often?: _____

Does your child take fluoride supplements or Fluoride Tablets? _____

Has your child complained about dental problems? _____ Explain: _____

Has your child had any injuries to their mouth? Teeth? Head? _____ Explain: _____

Does your child have any oral habits like: (thumb sucking, nail biting, mouth breathing, pacifier, etc.) _____

Child's attitude toward dentistry? _____

Do you desire complete dental service for your child? _____

Are you familiar with dental sealants? _____

Does your child have any unusual speech habits? _____

Does your child have any lost teeth? _____

Have any missing teeth been replaced? _____

Is your child wearing braces, (orthodontics)? _____

Any other dental or medical concerns you may have? _____

_____

This information was discussed with and given by: _____ Date: _____

Parent's Signature

Relationship to Child: _____