CHILD'S REGISTRATION AND HISTORY

DATE: _____

CHILD'S NAME_____ NICKNAME_____ AGE _____ DATE OF BIRTH _____

STREET_____ CITY_____ STATE, ZIP _____

HOME PHONE_____ CELL NUMBER _____ EMAIL _____

SCHOOL_____ GRADE _____

FATHER'S NAME_____ MOTHER'S NAME _____

FATHER EMPLOYED BY_____ ADDRESS_____ BUS PHONE_____

MOTHER EMPLOYED BY_____ ADDRESS _____ BUS PHONE _____

PERSON FINANCIALLY RESPONSIBLE (IF OTHER THAN PARENT) _____

STREET_____ CITY_____ STATE, ZIP _____

FATHER'S SOCIAL SECURITY NUMBER_____ DATE OF BIRTH _____

MOTHER'S SOCIAL SECURITY NUMBER_____ DATE OF BIRTH _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

WHAT IS CHILD'S FAVORITE SPORT? _____ SPECIAL INTERESTS _____

DENTAL ASSESSMENT

Date of last visit to a dentist: _____

For what service? _____

Has child complained about any dental problems? ❑ Yes ❑ No

Any unhappy dental experiences? ❑ Yes ❑ No

If Yes, explain _____

_____

Any injuries to mouth, teeth, head? ❑ Yes ❑ No

If Yes, explain _____

_____

Any oral habits: thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.? ❑ Yes ❑ No

Any unusual speech habits? ❑ Yes ❑ No

Any orthodontic application worn now or at any time? ❑ Yes ❑ No

Does your child brush teeth daily ? ❑ Yes ❑ No

Do you assist child with tooth brushing? ❑ Yes ❑ No

How often? _____

Is fluoride taken in any form? ❑ Yes ❑ No

If Yes, what form _____

Child's attitude to dentistry: _____

_____

Do you desire complete dental service for the child? ❑ Yes ❑ No

Summary: _____

_____

_____

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

Is child under care of physician now? ❑ Yes ❑ No

Is child receiving any medication or drug? ❑ Yes ❑ No

Is there any excessive bleeding when cut? ❑ Yes ❑ No

Has child ever been hospitalized? ❑ Yes ❑ No

Has child ever had surgery? ❑ Yes ❑ No

Is there any allergy to penicillin or other drugs? ❑ Yes ❑ No

Are there other allergies: food-pollen-animals? ❑ Yes ❑ No

Does child have good physical coordination? ❑ Yes ❑ No

Are there any emotional problems? ❑ Yes ❑ No

Does your child have a heart murmur? ❑ Yes ❑ No

Has your child ever had a blood transfusion? ❑ Yes ❑ No

Does your child have any developmental or perceptual disabilities? ❑ Yes ❑ No

Are your child's vaccinations up to date? ❑ Yes ❑ No

Summary _____

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

- ☐ Anemia
- ☐ Asthma
- ☐ Bladder
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Sinus
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hearing
- ☐ Heart
- ☐ Hepatitis
- ☐ HIV Virus
- ☐ Kidney
- ☐ Latex Allergy
- ☐ Liver
- ☐ Malignancies
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Other _____

SUMMARY: _____

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

This information was discussed with and given by _____

Relation to child _____

Signature of Parent or Legal Guardian _____