



Child's Registration

Child's Name _____ Birthdate _____

Address _____ Phone # _____

School _____ Grade _____ SS# _____

Mother's Name _____ Father's Name _____

Child's Favorite Sport _____ Favorite Toy _____

Financially Responsible Party Name _____

Home Phone _____ Employer _____

Bus Phone _____ SS# _____ Date of Birth _____

Address _____

Email Address _____ Cell Phone _____

Has any member of your family been treated in our office previously? Yes No

Whom? _____

Referred By _____

Dental Insurance Information

Employee _____ SS# _____

Birthdate _____ Employer _____

Patient's Relationship to Employee _____

PLEASE COMPLETE REVERSE SIDE

Dental History

Check any of the following dental problems:

Date of last dental visit _____ For what service? _____

Dentist Name _____ Phone Number _____

Address _____

Has your child complained about dental problems? Yes No

What? _____

Unhappy Dental experiences? Yes No What? _____

Injuries to mouth-teeth-head? Yes No What? _____

Mouth Habits: Thumb or Finger sucking - Yes No Mouth Breathing- Yes No Nail Biting- Yes No

What? _____

Unusual Speech Patterns? Yes No What? _____

Lost Teeth? Yes No Which? _____

Orthodontic Evaluation or Orthodontic Treatment (Braces) Yes No

How often does your child brush their teeth? _____

Do you assist with child's brushing? Yes No Is dental floss used? Yes No

Is fluoride taken in any form? Yes No What dosage? _____ Do you have city water? Yes No

Child's attitude toward their teeth/dentistry? _____

Medical Information

Child's Physician's Name _____ Phone _____

Address _____

Date of last medical examination _____ Results _____

Is child presently under a physician's care? Yes No What for? _____

Has child ever been hospitalized? Yes No What for? _____

Has child ever had surgery? Yes No What for? _____

Any past serious illnesses? Yes No

Is child taking any drugs, medicines or injections? Yes No If so, what? _____

Any allergies or reaction to any medicines such as penicillin, novocaine, aspirin, or codeine? Yes No

Explain _____

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

_____ Anemia	_____ Chronic Sinus	_____ Hearing	_____ Mastoid
_____ Asthma	_____ Convulsions	_____ Heart	_____ Measles
_____ Bladder	_____ Diabetic	_____ Kidney	_____ Mononucleosis
_____ Cerebral Palsy	_____ Epilepsy	_____ Liver	_____ Mumps
_____ Venereal Disease	_____ Fainting	_____ Malignancies	_____ Tumors
_____ Rheumatic Fever	_____ Aids	_____ Chicken Pox	_____ Emotional Problems
_____ Thyroid	_____ Tuberculosis	_____ Hepatitis	_____ HIV Positive

Please describe any medical treatment not described above.

All of the information is considered confidential and will only be used in the course of your dental treatment. I understand that I am financially responsible for all dental services rendered.

Signature _____ Date _____