



CHILD'S REGISTRATION AND HEALTH HISTORY

DATE _____

DATE OF BIRTH _____ AGE _____

CHILD'S NAME _____

NICKNAME _____

RESIDENCE-STREET _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

MOTHER'S NAME _____

SOCIAL SECURITY NO. _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

WORK PHONE _____

FATHER'S NAME _____

SOCIAL SECURITY NO. _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____

WORK PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

NAME OF DENTAL INSURANCE CO. AND ADDRESS _____

POLICY HOLDER MR. or MRS.

POLICY NUMBER _____

PURPOSE OF THE CALL _____

REFERRED BY: FRIEND _____

RELATIVE _____

YELLOW PAGES

OTHER _____

DATE OF LAST MEDICAL EXAMINATION _____

DOES THIS CHILD HAVE OR HAVE THEY EVER HAD:

	YES	NO
ANEMIA	_____	_____
ASTHMA	_____	_____
DIABETES	_____	_____
EMOTIONAL PROBLEMS	_____	_____
HEPATITIS - A, B, NON AB	_____	_____
WHEN? _____		
ALLERGY TO PENICILLIN	_____	_____
TO LOCAL ANESTHETIC	_____	_____
TO OTHER (LIST) _____		

AIDS (HIV POSITIVE OR ARC)

ABNORMAL BLEEDING FROM A CUT

RHEUMATIC FEVER

HEART MURMUR

IS THE CHILD TAKING ANY MEDICATION? _____

IF SO, WHAT? _____

OTHER PHYSICAL CONDITIONS _____

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN NOW?

NAME OF PHYSICIAN _____

TELEPHONE NUMBER _____

THIS INFORMATION IS CORRECT AND GIVEN BY:

Signature: _____

RELATION TO CHILD _____

OVER

OPTIONAL

BELOW ARE A LIST OF QUESTIONS.
ANSWER ANY OR ALL OF THESE THAT MAY HELP US SERVE YOU AND YOUR CHILD BETTER.

WHAT ARE YOUR MAIN CONCERNS ABOUT THIS VISIT? _____

HAS DENTAL TREATMENT BEEN RECOMMENDED THAT HAS NOT BEEN DONE? YES NO

YOUR CHILD'S CONCERNS? _____

DOES THEIR DRINKING WATER HAVE FLOURIDE IN IT? YES NO NOT SURE

DOES YOUR CHILD A)DREAD, B)WORRY ABOUT, C)DOESN'T MIND HAVING DENTAL WORK DONE?

DOES YOUR CHILD BRUSH AND FLOSS THEIR TEETH DAILY? YES NO

ANY UNHAPPY DENTAL EXPERIENCES? _____

DOES SOMEONE ASSIST YOUR CHILD WITH BRUSHING & FLOSSING? YES NO

WHAT IS YOUR CHILD'S INTERESTS? _____

WOULD YOU SAY YOUR CHILD HAS A WELL-BALANCED DIET? YES NO

TEACHER'S NAME _____

FAVORITE SPORT _____, TOY _____

PERSON _____

FICTIONAL CHARACTER _____

OTHER _____

WE'RE INTERESTED IN YOUR CHILD'S GOOD HEALTH. IF WE HAVEN'T EXPLAINED THINGS CLEARLY OR IF YOU HAVE UNANSWERED QUESTIONS PLEASE LET US KNOW. WE ALSO HAVE PRINTED INFORMATION AVAILABLE FOR YOU ON DIET AND DENTAL HEALTH (BRACES, BONDING, CARE OF CHILDREN'S TEETH, PIT & FISSURE SEALANTS, ETC.). WE WANT TO HELP YOU FOSTER GOOD DENTAL HABITS FOR YOUR CHILD. THIS WILL HELP THEM KEEP A HEALTHY SMILE FOR A LIFE TIME.

THANK YOU