CHILD REGISTRATION & MEDICAL HISTORY

Child's Name ______________________ Nickname ______________

Date of Birth __________ Age_____ School ____________________ Grade ______

Home Address ____ Sex: M/F

City, State, Zip Code _______________________ Phone _____________________

Parent or Person Responsible For Account

Name _______________________________ Relation to Child ______________

Marital Status: Single/ Married Sex: M/F Date of Birth _________________

Social Security Number _____________________ Phone(if different) _______________

Address (if different) ____

City, State, Zip Code____

Dental Insurance _______________________ Employer ___________________

Dental History

Does child: Suck Thumb/ Fingers ____ Yes No Date of Last Dental Visit:______________

Chew Lips/ Cheeks _____ Yes No Grind Teeth __________ Yes No

Has child experienced any unfavorable reactions from any previous dental treatment? If so, please explain: ____

____

Health History

List any prescription medication your child is taking and why:__________________________

____

Please circle Yes or No to each question:

Allergies (include antibiotics) ________ Yes No
If so, please list:________________
____

ADD/ADHD ______________ Yes No
Cancer ________________ Yes No
Diabetes _______________ Yes No
Rheumatic Fever ____________ Yes No
Heart Murmur_______________ Yes No
Mitral Valve Prolapse __________ Yes No

Asthma _________________ Yes No
If yes, do you carry an inhaler? Yes No
Handicaps/Disabilities__________ Yes No
Seizures/Epilepsy__________ Yes No
Hepatitis________________ Yes No
Abnormal Bleeding __________ Yes No
Hemophilia _____________ Yes No
HIV/AIDS _______________ Yes No
Tuberculosis______________ Yes No

Please explain any medical or dental problems that your child has: ____________________

____

Patient's primary physician:________________________ City ________________

How did you hear about us?____

Parent or Guardian's Signature_________________________________ Date: ________