CHILD'S REGISTRATION AND HISTORY

Today's Date: _____/_____/_____

Child's Name _____ Prefers to be called _____

Home Address _____

City _____ State _____ Zip _____

Age _____ Date of Birth_____/_____/_____ Sex: M ◯ F ◯ Weight_____

What other children in your family have we seen? _____

So that we may thank them, who referred you to our office? _____

Person financially responsible for the this account is _____ Phone No. (___)_____

Relationship to patient _____ Driver's License No. _____

Address (if different from patient) _____

City_____ State_____ Zip_____

Employer_____ Business Phone No.(___)_____

Insurance Company _____ Group No. _____ Employee_____

Employee Social Security #_____/_____/_____ Date of Birth _____/_____/_____ Date Employeed _____/_____/_____

CHILD'S MEDICAL HISTORY

Please check any of the following that your child has or has had a history of. (Please check YES or NO for each item)

	YES	NO		YES	NO
1. Any known physical disorder	◯	◯	13. Sickle Cell Disease/trait	◯	◯
2. Congenital birth defects	◯	◯	14. Hemophilia/abnormal bleeding	◯	◯
3. Mental/physical development delays	◯	◯	15. Kidney ailments	◯	◯
4. Behavioral/learning problems	◯	◯	16. Stomach/intestinal ailments	◯	◯
5. Endocrine system problems	◯	◯	17. Liver ailments	◯	◯
6. Drug allergies (ie.,Penicillen,Codeine)	◯	◯	18. Seizures/Epilepsy	◯	◯
7. Breathing/lung problems (Asthma)	◯	◯	19. Diabetes	◯	◯
8. Tuberculosis	◯	◯	20. Sight/hearing impairments	◯	◯
9. Heart disease/Murmur/Shunt	◯	◯	21. Rheumatic Fever	◯	◯
10. Cancer/tumors	◯	◯	22. HIV+/AIDS	◯	◯
11. Blood dyscrasia/disorder	◯	◯	23. Recurrent/frequent headaches	◯	◯
12. Blood transfusion (Date___/___/___)			24. Any operations/hospitalization	◯	◯

Is your child in good health? YES ◯ NO ◯ Is your child up to date on immunizations? YES ◯ NO ◯

I your child taking any medications? YES ◯ NO ◯ If yes, what and does: _____

Date of last medical exam _____/_____/_____ Pediatrician and phone no. _____(____)_____

CHILD'S DENTAL HISTORY

HAS YOUR CHILD EVER HAD:	YES	NO		YES	NO
1. Jaw locking/popping/pain	◯	◯	9. Complaints of painful/sensitive teeth	◯	◯
2. Grinding teeth	◯	◯	**DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?**		
3. Any injuries to the mouth, face, teeth, head	◯	◯	1. Thumb/finger sucking	◯	◯
4. A toothache/dental problems	◯	◯	2. Pacifier	◯	◯
5. Frequent cold sores or blisters	◯	◯	3. Lip sucking/lip biting	◯	◯
6. Have sore or bleeding gums	◯	◯	4. Nail biting	◯	◯
7. Oral Surgery	◯	◯	5. Mouth breathing	◯	◯
8. Still drink from bottle or breast	◯	◯	Date of last radiographs: _____/_____/_____		

Date of last dental exam: _____/_____/_____

EMERGENCY INFORMATION

Person to contact in case of emergency _____

Please list phone numbers where they may be reached (___)_____ or (___)_____

Address_____City _____State_____Zip_____

PATIENTS QUESTIONS

How do you expect your child to react in the dental chair? ☐ Very well ☐ Moderately Well ☐ Fair ☐ Poor

Has your child had any unhappy dental experiences? ☐ Yes ☐ No

Please identify reasons for todays visit and any dental or medical problem of special concern.

Also, provide any other information which you think might be important in the care of your child _____

_____

_____

Child's previous dentist (if any): _____Phone No. (_____)_____

CARE OF PATIENTS

If this is your child's first visit to the dentist and if cooperation permits, teeth may be cleaned and x-rayed, if the child is suffering from a toothache, emergency treatment will be provided. No fillings or extractions will be done on the child's first visit. An account of the services to be rendered and cost of the complete case will be given to the parent before any treatment has begun.

In providing dental care, we will treat your child as we would our own. Numbing agents and laughing gas are used routinely to help overcome the fear of dental care. When cooperation is poor, other forms of conscious sedation may be needed. Dentistry is an important health service, and we will attempt to provide your child a satisfying experience in our office. The infection control measures we practice are designed to protect you and us from such infections as hepatitis, tuberculosis, AIDS and respiratory viruses such as the common cold. Our sterilization procedures minimize the risk of cross contamination.

CONSENT FOR TREATMENT

The undersigned hereby authorizes our office to perform the examination including x-rays, and after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effective until cancelled by either party.

This information was given by: _____Date_____/_____/_____

Signature X_____

Relationship to child _____Reviewed by office staff:_____