

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 Employed _____

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
Is 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 today's 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: _____